

# Medical Records

## OUTPATIENT MEDICAL RECORD

**Patient Identification**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

**Alert**

Allergies  
 Sensitivities

This area reserved for bar code label

Health Record  
 Outpatient Treatment Record

Military \_\_\_\_\_ (provide service and grade or rate)  
 Retired \_\_\_\_\_ (provide service and grade or rate)  
 Nonmilitary \_\_\_\_\_ (provide sponsor's service & status)

Personnel Reliability Program  
 Blood Type  
 Flight Status  
 Food Handler

Radiation Exposure  
 Asbestos Surveillance  
 Medical Condition

NAVVED 018030 (6-94)  
S/N 0106-LF-017-0000

1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012

# **Chapter 16**

## **Contents**

---

<b>Sections</b>	<b>Page</b>
Section I <b>General</b>	16-3
Section II <b>Basic Information that Applies to all Medical Records</b>	16-13
Section III <b>Basic Types of Medical Records</b>	16-27
Section IV <b>Medical Records for Operational Medical Departments</b>	16-37
Section V <b>Specialty Records</b>	16-41
Section VI <b>Medico-Legal Issues</b>	16-49
Section VII <b>Instructions for Completing Selected Forms</b>	16-61
Section VIII <b>Abbreviations, Acronyms, and Definitions</b>	16-77

---

# Section I General

<b>Article</b>	<b>Page</b>
16-1 <b>Purpose</b>	16-3
16-2 <b>Scope</b>	16-3
16-3 <b>Philosophy</b>	16-4
16-4 <b>Policy Development and Point of Contact</b>	16-4
16-5 <b>Purpose and Uses of the Medical Record</b>	16-4
16-6 <b>Major Medical Record Categories</b>	16-4
16-7 <b>Secondary Records</b>	16-5
16-8 <b>Indices, Registers, and Logs</b>	16-7
16-9 <b>Security and Safekeeping</b>	16-8
16-10 <b>Ownership and Custody of Medical Records</b>	16-9
16-11 <b>Responsibilities</b>	16-10
16-12 <b>Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</b>	16-11

## **16-1**

### **Purpose**



(1) To provide the Medical Department activities with guidance for medical records administration, including preparation, maintenance, retention, and disposal standards.

## **16-2**

### **Scope**



(1) This guidance applies to all Department of the Navy (DON) medical departments, both fixed and nonfixed, and includes medical records maintained for both U.S. Navy (USN) and U.S. Marine Corps (USMC) personnel, their dependents, civilian employees, and other beneficiaries. Referral to medical records includes records maintained by both medical and dental treatment facilities (MTFs and DTFs) and to medical records in both paper and automated formats.

**16-3****Philosophy**

(1) Direction is provided where consistency is essential. Autonomy extending beyond the direction provided in this chapter is encouraged when local initiatives improve the documentation of health care provided.

(2) The efficient management of medical records is essential. Personnel responsible for maintaining the patients' records are vital to the initiation and completion of the health care delivery process.

(b) Furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during treatment.

(c) Document communication between the practitioner responsible for the patient and all other health care professionals (HPs) who contribute to the patient's care.

(d) Assist in protecting the legal interest of the patient, the MTF or DTF, the practitioner responsible for the patient, the USN, and the U.S. Government.

(e) Provide data for use in continuing education and research.

(f) Justify costs incurred by third party payers.

(g) Serve as a vehicle for communication among health care providers, utilization management, risk management, quality assurance, medical records personnel, and outside agencies.

(3) Accuracy and completeness in recording entries and medical record filing and maintenance is of the utmost importance.

**16-4****Policy Development and Point of Contact**

(1) Policy development is an ongoing process and all MTFs and DTFs are strongly encouraged to become involved. Submit ideas to the Chief, Bureau of Medicine and Surgery (BUMED), Patient Administration Division, Medical Records Branch (MED-335), 2300 E Street NW, Washington DC 20372-5300. MED-335 is the point of contact for all inquiries and recommendations for improvement to the systems, procedures, and forms in this chapter.

**16-6****Major Medical Record Categories**

(1) **Medical Record Definition.** An account compiled by physicians and other health care professionals of a patient's medical history, present illness, findings on examination, details of treatment, and progress notes. The medical record is a legal record of care.

(2) **Primary Records.** Primary records are the original records established to document the continuation of care given to a beneficiary. There are three major categories of primary records: health records (HRECs), outpatient records (ORECs), and inpatient records (IRECs). Dental records (DRECs) are part of HRECs and ORECs, and are discussed in section III and chapter 6.

(a) **Health Records (HRECs).** A file of continuous care given to an active duty (AD) member. It is also known as the employee medical file (EMF) for Federal civil service employees (FCSEs), per chapter 293 of the Federal Personnel Manual (FPM). The HREC documents all outpatient care and serves as the unit record for purposes of accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). While the HREC primarily documents ambulatory care, copies of inpatient narrative summaries and operative reports are also placed in the HREC to provide continuity of health care documentation.

**16-5****Purpose and Uses of the Medical Record**

(1) The purpose of the medical record is to provide an individual chronological record of medical treatment afforded members of naval service. The record has significant current and long-term medico-legal value to the individual concerned, their survivors, and the U.S. Government. Medical, dental, and occupational health examinations, evaluations, and histories, as well as evaluations of illnesses and subsequent treatments, are documented in this record.

(2) Medical records are used to:

(a) Plan patient care and evaluate the patient's condition and treatment.

(b) **Outpatient Records (ORECs).** A file of continuous care which documents ambulatory treatment received by a person other than an active duty member.

(c) **Inpatient Records (IRECs).** A medical file which documents care provided to a patient (inpatient) assigned to a designated inpatient bed in an MTF or ship.

(d) **Distinction between HRECs and ORECs.** There is a distinction made between the HREC and the OREC, because active duty members and FCSEs have routine and periodic medical requirements (i.e., special duty physical examinations, occupational and preventive medicine surveillance, etc.) that require documentation that is not required for other health care beneficiaries.

(e) **Commercially Developed Record Jackets.** Commercially developed record jackets and filing systems shall not be used in lieu of the prescribed standard forms and systems.

## 16-7 Secondary Records

### (1) General

(a) Secondary records are medical records which are maintained separate from the primary record, and must follow the guidelines established by this manual and the local medical records committee (MRC). These records are kept in a separate file secured in a specialty clinic or department of fixed MTFs. These records include convenience records, temporary records, and ancillary records.

(b) Because the primary health care providers (HPs) of active duty personnel (such as shipboard medical departments, etc.) must be aware of their crew's medical status at all times, temporary or ancillary records will not be opened or maintained for active duty personnel. The exceptions to this are records for obstetrics/gynecology (OB/GYN), family advocacy, or psychology/psychiatry clinic records. MTFs needing additional exceptions to this policy must request approval from BUMED (MED-02 & 335). When temporary or ancillary records (see article 16-7(2)(b)) are maintained for active duty personnel, copies of information placed in the secondary record will be placed in the original health record at each visit.

(c) The HP creating a secondary record should write a note stating the nature of the secondary record, the patient's diagnoses, and the clinic or department name, address, and telephone number on the NAVMED 6150/20, Summary of Care, of the patient's primary record. Make a

second entry on the NAVMED 6150/20 when the secondary record is closed. The HP must ensure that complete, up-to-date entries are made to the NAVMED 6150/20 in the patient's secondary and primary records. Exceptions to this may be adolescent clinic records, or other records identified by the Medical Records Committee (MRC).

(d) Reasons to maintain secondary medical records:

(1) To ensure the privacy of the patient.

(2) To prevent the accidental or deliberate loss of valuable information.

(3) To keep the primary record free of voluminous support documentation and notes used to determine the appropriate course of treatment.

(4) To segregate sensitive patient information from the primary record.

(2) **Secondary Records.** There are three kinds of secondary records commonly used:

(a) **Convenience Records.** Contain a copy of excerpts from a patient's primary treatment record and kept within the MTF by a treating clinic, service, department, or individual physician for increased access to the information. When its purpose has been served, the establishing clinic, service, department, or individual purges the file - comparing it to the primary medical record and adding missing information to assure completeness.

(b) **Temporary Records.** An original medical record established and retained in a specialty clinic, service, or department in addition to the patient's primary treatment record. Its purpose is to ensure the timely availability of information that documents a current course of treatment. The temporary record becomes a part of the primary treatment record when the course of treatment has been completed. This record is most commonly established in OB/GYN for a prenatal patient. When the temporary record is disestablished and joined with the HREC, OREC, or IREC note this in the primary HREC or OREC on the NAVMED 6150/20.

### (1) Construction and Maintenance of Temporary Records

(a) Open a separate record folder for each patient when a temporary record is started. To conserve the more expensive terminal digit-SSN (TD-SSN) folders, use manila folders for temporary medical records. Record the patient's name, family member prefix (FMP), SSN, name of clinic maintaining the temporary record, and name of the MTF on the front of the folder.

(b) When receipt of a primary record is delayed, (e.g., when the patient is transferred from a previous assignment), a temporary record may be established until the primary record is received.

(c) File temporary records either by TD-SSN or alphabetically by the patient's last name.

(d) For Secretary of the Navy (SECNAV) Designee Obstetrical Patients, file both prenatal and postnatal visit records of females who deliver babies as SECNAV designees with the patients' inpatient delivery records. Ex-service maternity patients are SECNAV designees.

(2) **Disposition of Temporary Records.** At the end of the course of treatment, for which a temporary record was established, the holding clinic or department must submit the temporary record to the medical records branch (MRB) or IREC office, as appropriate, to join with the primary record. The MRB will combine the temporary medical record with the primary record before retirement of the primary record. Do not retire temporary medical records separately.

(c) **Ancillary Records.** Ancillary records consist of original health care documentation withheld from a patient's primary health record or OREC. In certain cases it may be advisable to not file original treatment information in the primary treatment record, but instead to a secondary treatment record, to which the patient, parent, or guardian has limited access. Examples of such instances include information that is potentially injurious to the patient, or information that requires extraordinary degrees of protection due to the sensitivity of the information contained therein (e.g., psychiatric treatment, instances of real or suspected child or spouse abuse, etc.). The information may also be used for medical studies and brought to the attention of the respective commanding officer (CO) or executive committee of the medical staff (ECMS), if appropriate.

(1) **Construction and Maintenance of Ancillary Records.** Open a separate terminal digit folder for each patient for whom an ancillary record is established. The procedures for establishing and maintaining HRECs and ORECs, in sections II and III of this chapter are applicable, except as follows:

(a) Stamp or print on the front of the ancillary record folder: **SECONDARY RECORD** in 1/4-inch block letters between the patient identification block and the alert block. Mark an **x** in the outpatient square in the record category box. Stamp or print on the NAVMED 6150/20 of the primary HREC or OREC **SECONDARY RECORD EXISTS**.

(b) If transfer is necessary, transfer ancillary records from the holding MTF to another MTF in a double sealed envelope. Label the outside envelope **FOR COMMANDING OFFICER'S EYES ONLY**, and the inside envelope **For Official Use Only-Restricted Circulation** in 1/4-inch block letters and identify the clinic where the record is to be maintained.

(2) **Disposition of Ancillary Records.** When an ancillary record is closed because treatment has been completed, send the record to the MRB. The MRB person-

nel, if agreed on by the provider, clinical service, and the medical records administrator (MRA), will combine the ancillary record with the primary record, disposing of duplicate reports and entries.

(a) If the ancillary record is not combined with the primary record, MRB personnel retire it separately to the NPRC. The MRB must maintain a log that identifies when and to where the record was retired.

(b) If there is reason to protect the information in the record, the clinic that maintains the record must place a memorandum on the inside of the record, top right-hand side. The memorandum should state any release restrictions and the reasons for the restrictions.

(c) When care is terminated due to transfer of the patient, forward the record to the cognizant MTF. If care is to be provided by a civilian provider, send a copy of the ancillary record to the civilian provider and retire the original ancillary record to NPRC through the MRB.

(3) Providers may not take original ancillary records with them when they transfer. They must use copies of the records for research, board certification, or other authorized purposes.

(3) **Discovery.** All secondary records are subject to the provisions of the Privacy Act of 1974, as well as local and State laws and regulations. They are discoverable in a court of law; open to patient review; available to internal investigation bodies, such as the Naval Investigative Service (NIS); and protected from people seeking information outside of the law.

(4) **Custody.** When approved, store secondary records in a secure location separate from primary treatment records. Although secondary records frequently are not filed in the MRB, they are maintained under the jurisdiction of the medical record program administrator.

(5) **Authority to Establish Secondary Records.** A specialty service or department wishing to withhold or remove information from a patient's primary treatment record, in the patient's best interest, and establish secondary records, must request approval from the MTF's medical records committee (MRC).

(a) The service or department head must provide a full explanation of the need and anticipated uses for the proposed secondary records.

(b) Determination to establish and maintain a secondary record on an individual being treated by a service, other than the services permitted by the MRC to routinely maintain secondary records, is based on a written request by the attending physician and approved by the command's MRC.

(c) The MRC must evaluate each request and, if determined to be well founded, instruct the medical records administrator (MRA) to take action to remove or withhold the identified information from the patient's primary record,

placing it in the secondary record. The HP will enter a brief note on the NAVMED 6150/20, in the primary treatment record, stating the general nature of the information removed or withheld.

(d) The MRA maintains a list for the MRC of all secondary record approvals for inclusions in the MRC minutes.

(e) The information may also be used for medical studies and brought to the attention of the respective commanding officer (CO) or Executive Committee of the Medical Staff (ECMS), if appropriate.

(6) **Annual Inventory.** The MRA will conduct an annual survey of all secondary records. The MRA will report results of this survey to the MTF's MRC. See articles 16-14 and 16-23 for additional guidance on preparation and maintenance of secondary records.

(7) **Documentation**

(a) Secondary records may contain information such as questionnaires, psychological testing instruments, or other information used in formulating entries for the HREC or OREC. Reference this information in the HREC or OREC. Copies of information contained in the HREC, OREC, or IREC may be stored in the secondary record. Secondary records do not contain progress notes which are maintained in an HP's personal file.

(b) When an entry is made in the secondary record, it will be documented in the patient's primary HREC or OREC. Inform the patient that entries will be made to both the primary and secondary records.

(c) Documentation in the primary record shall be in enough detail for another practitioner to assume the care of the patient at any time and to stand alone legally. Make entries on the SF 513 for initial consults and on the SF 600 for later visits. Make a full SF 600 entry, to include:

- (1) Date.
- (2) MTF name.
- (3) Clinical department or service.
- (4) Practitioner's name, profession or corps, rate or grade, and SSN.
- (5) Chief complaint or purpose of visit.
- (6) Objective findings.
- (7) Diagnosis or medical impression.
- (8) Studies ordered and results, such as laboratory, x-rays, or psychological studies.
- (9) Therapies administered.
- (10) Disposition, recommendations, and instructions to the patient. See article 16-58.

(8) **A specialty secondary record** is generally a primary HREC or OREC that documents a patient's diagnosis and therapy or care. It is established and kept within an MTF under guidance other than this chapter (e.g., family advocacy and dental). Specialty records are discussed in detail in section IV.

(9) **Family Advocacy Program (FAP)** records are covered by a NAVMEDCOMINST 6320.22 series and article 16-31. They are considered to be ancillary (secondary) records as well as specialty records and are an exception to article 16-7(5)(c). An entry is made on the NAVMED 6150/20 in the primary record and the FAP record only when a FAP record is opened, reopened, or closed.

(10) **Secondary records of adolescents** are another exception to article 16-7(5)(c).

(a) Most States have laws which protect the privacy of minors who receive adolescent, sexual, and developmental medical care or counseling. State law and local guidance determine what, if any, information goes into the primary record. In the absence of State or local guidance, the MRC will set policy on the documentation which will be placed in these records.

(b) Some State laws prevent a parent or guardian from having access to an adolescent's medical record. To secure this information, adolescent clinics should establish and maintain these secondary records apart from the primary record. A cover letter should be placed on the top right-hand side of the record that says, per State law the record is only to be released to the patient.

(c) When a minor leaves the area, a copy of the secondary record should be made available to them.

(11) **Closure.** When the case covered by a secondary record is closed, submit it to the MRB for combining with the primary record or retirement with the next scheduled shipment to NPRC. Combine the secondary record with the primary record only with the consent of the head of the cognizant service or department. Retire to NPRC each secondary record which cannot be combined with the primary record.

(12) **Disposition of Secondary Records.** The secondary record may be retired with the annual retirement of ORECs when not active for 2 years.

## 16-8

## Indices, Registers, and Logs

(1) This category includes indices, registers, logs, treatment cards, and locator cards or other grouped administrative information kept by an MTF which is identified by an individual patient or provider. This includes logs and registers in which patient care services are documented. Information contained in these secondary medical documents is summarized in the patient's medical record.

(a) **Indices.** Indices contain the minimum information necessary to fill requests for data about patients, such as their diagnoses, chief complaint, and the type of service provided.

(b) **Registers and Logs.** Registers and logs provide chronological lists of data, which are developed and maintained by a clinic, service, or department as a reference or control for basic information about the numbers and types of patients treated. Examples are operating room logs, emergency room logs, tumor registries, admission registry logs, and clinic appointment schedules.

(2) Retention periods for indices, registers, and logs are in SECNAVINST 5212.5 series.

## 16-9

### Security and Safekeeping

(1) Each MTF or medical department must develop policies to ensure that the record is secure and the patient's privacy is protected. Security and safekeeping are major concerns and responsibilities of staff handling all categories of medical records and secondary sources of medical information. All these resources contain information which is personal to patients, is treated as privileged information, and is protected by the Privacy Act of 1974. See section VI.

(2) Take necessary precautions to avoid compromise of medical information during the movement of records within and from the MTF to any person authorized to receive them.

(3) Restrict access to medical records to authorized medical service personnel except as otherwise noted in this section.

(4) Keep all medical records in a locked area, room, or file to ensure safekeeping, unless there is a 24-hour watch in the records office.

(5) When a medical record is removed from a secure area, such as in a clinic, inpatient area, or HP office, it receives the same level of security as in the MRB.

(6) Safeguarding Medical Information

(a) Confidentiality. Information in the medical record is personal to the individual and must be properly safeguarded. It is handled in confidence so that personal information is not made known to unauthorized persons. Nothing in this section, however, prevents:

(1) Releasing information on the current health and welfare of individual patients to appropriate persons

or releasing vital statistical data, including proof of birth or death.

(2) Complying with court orders or subpoenas to produce medical records for litigation (law suits) or criminal prosecutions.

(3) Releasing information from medical records following current laws.

(4) Releasing information from medical records at the written request of patients or their legal representatives as specified in this section.

(5) MTFs complying with laws regarding the maintenance, use, and release of information.

(6) Only enough information to accomplish the purpose for which it is requested.

(7) Original medical records are not to be released to any person or agency outside the Executive Branch of the Government. Copies of pertinent pages of the record may be released when requirements of this section are met.

(8) When information is released to a third party, further release is not authorized, without consent of the patient, his or her legal representative, or the agency having records responsibility.

(9) Personnel working with medical records must understand the law, policies, and procedures governing the maintenance, use, and release of HRECs or medical documents. The details described in this section must be included in all inservice training programs for patient administration personnel.

(b) Sensitive Medical Information. Information which may negatively affect the patient's morale, character, medical progress, or mental health is considered sensitive. To protect the sensitive nature of the information, records or documents may be:

(1) Stamped: **SENSITIVE MEDICAL INFORMATION** before release or referral outside of the MTF.

(2) Placed in a sealed envelope stamped: **MEDICAL INFORMATION - FOR USE BY AUTHORIZED PERSONNEL ONLY.**

(3) Handcarried only by trustworthy personnel.

(4) Sent directly through medical channels when this is considered advisable by the physician or MTF commander (CDR), CO, or officer in charge (OIC).

(7) Written Consent Required

(a) Except for conditions established by the Privacy Act of 1974 and SECNAVINST 5211.5 series, information from medical records is not released to any person or agency without the written consent of the persons concerned or their legal representatives.

(1) For dependent minor children, either parent signs the consent.

(2) For deceased persons, the next of kin signs and furnishes proof of death.



(3) For physically or mentally incompetent persons, the guardian signs and furnishes a court order appointing guardianship.

(b) If litigation is pending or contemplated, the request for release is sent to the staff judge advocate for advice and appropriate action.

(8) Release of Information on Adopted Infants. Special care must be taken on the release of information from the records of newborns who have been released for adoption. Before the information is released, all references to the child's natural parents must be deleted. Stamp the in-patient folders of these newborns: **RELEASE OF INFORMATION RESTRICTED.**

(9) Schedule of Fees for Copying Medical Records

(a) Fees for copying, certifying, and searching medical records are listed in NAVCOMPTMAN, volume 3, articles 035875 and 035887. See also SECNAVINST 5211.5 series for requests under the Freedom of Information Act (FOIA) and the Privacy Act of 1974. There is no charge when information is requested for the purpose of obtaining further medical care.

(b) Advance payments for requests for information from medical records may be accepted. If the request is for a large volume or requires extensive research, the MTF notifies the requestor of any additional charges.

## 16-10

### Ownership and Custody of Medical Records

(1) The medical record is the property of the U.S. Government and must be maintained by the MTF or DTF which has primary cognizance over the care of the patient. They are of continuing long-term interest to the Government and the patient, and must be maintained within an MTF or DTF. A patient may not retain original HRECs, ORECs, or dental records. When it is found that a record is being held by an individual without proper authorization, notify the MTF CO or OIC who is the custodian of the medical and dental records. He or she then initiates action, through appropriate channels, to get the record returned to the MTF. Handcarrying medical records by unauthorized individuals (e.g., spouses or siblings of the patient) without a written authorization is prohibited. Records of minor dependent children, as defined by State or local law, may be handcarried by the parent or sponsor. In cases where parents are divorced, only the parent (or sponsor of the child) having custody of the child is authorized to handcarry the record. Record jackets of these re-

ords may be marked to indicate this fact. Evidence of custodianship (court orders, divorce papers, etc.) should be placed in the record if provided by the parent having custody, to establish this relationship.

(2) To avoid the frequent handcarrying of records by patients, the MTF or DTF should establish systems that allow delivery of records to clinics for scheduled appointments, as well as for other patient contacts when feasible. The MTF or DTF should also establish systems to retrieve records from patients when the record is handcarried by them.

(3) All staff members should be prohibited from returning a medical record to the patient's control at the end of the clinic visit, except when the patient is in a permanent change of station (PCS) status or is referred from an MTF outside of the geographic region.

(4) Each records office is required to have a system in place which identifies to whom, where, and when a record has been checked out, or in, and when a record has been checked out for an inordinate period of time. This information is used to effect return of the delinquent record. See section II.

(5) Maintain health and dental records of members of the Selected Reserves within a support MTF or DTF, where practical; otherwise, maintain the record at Navy or Marine Corps Reserve centers.

(6) DEERS and CHCS Medical/Dental Records Tracking System

(a) Use the Defense Enrollment Eligibility Reporting System (DEERS) and the Composite Health Care System (CHCS) Medical/Dental Records Tracking System in the CHCS computer system to log in the medical and dental records of each HREC and OREC as follows:

(1) Upon the PCS check-in of the member. This will allow for a worldwide and local system to ensure the HREC and DREC is promptly returned to the responsible MTF or DTF. Additionally, this ensures the patient is credited to your region for capitation funding.

(2) Upon the PCS check-out of the member to a shipboard assignment the MTF or DTF will enter the address of the gaining personnel support detachment (PSD) or personnel support activity (PSA) in the DEERS Medical/Dental Records Tracking System, to prevent the record from being returned to the losing MTF or DTF, and to ensure loose laboratory and x-ray chits are properly forwarded to the gaining PSD or PSA.

(3) Upon establishing or receiving the OREC of a nonmilitary patient.

(b) Use the CHCS Medical/Dental Records Tracking System to establish a tickler system to indicate when records are temporarily loaned to a clinic, and to get the records returned to the appropriate records room.

## 16-11 Responsibilities

(1) General. The responsibilities listed below pertain mainly to fixed MTFs.

(2) The BUMED Patient Administration Division, Medical Records Branch (MED-335), is responsible for administering the Navy's medical records program. This includes:

(a) Developing policies and program guidance on the management, construction, maintenance, transfer, automation, retirement, and disposal procedures for Navy medical records.

(b) Serving as technical advisor on medical-records management to BUMED subordinate activities and to Navy and Marine Corps operational units.

(3) CDRs, COs, and OICs of MTFs are responsible for implementing and complying with this chapter. As the official custodians of medical records, their responsibilities include:

(a) Ensuring that all medical records are prepared, maintained, used, and protected following this chapter, and that fixed facilities governed by BUMEDINST 6000.2 series comply with JCAHO standards for accreditation.

(b) Ensuring that an accurate, complete, and timely medical record is prepared for each patient evaluated or treated.

(c) Designating in writing, at fixed medical facilities, an MRA (preferably a registered records administrator (RRA) or an accredited records technician (ART)) credentialed by the American Medical Record Association as the command's medical records program administrator. At fixed naval MTFs subject to JCAHO accreditation, in the absence of an RRA or ART, the CO is responsible for assuring quarterly consultative visits by a qualified RRA or ART.

(d) Providing support to MRB personnel to include:

(1) Holding medical officers accountable for adequate and timely medical record documentation.

(2) Supporting guidance that prohibits patients' self-maintenance of medical records.

(e) Ensuring that local instructions are written and kept current.

(4) COs of deployable units, fleet hospitals, and hospital ships: See section IV.

(5) The Head, Patient Administration Department (PAD) is responsible for the administrative management of the MRB and ensures that providers of care are informed of documentation, maintenance, and release of information procedures in this manual, the Privacy Act of 1974, and

FOIA, and the JCAHO Accreditation Manual for Hospitals (AMH). These responsibilities include:

(a) Seeking the resources necessary to assure that the MRB is adequately staffed and equipped to fulfill its functions. This duty includes obtaining the services of a qualified medical records professional to serve as the medical records program administrator.

(b) Ensuring that medical records is part of the PAD Quality Assurance (QA) Program.

(c) Serving as a member of the medical records committee.

(6) The Head, MRB is ordinarily an RRA or ART, depending on the size and complexity of the MTF or DTF. The incumbent serves as the command's medical records program administrator (MRA) for HRECs, ORECs, and IRECs. Responsibilities include:

(a) Serving as the delegated custodian of medical records. This person acts for the CDR, CO, or OIC in the management of medical records and has direct access to the medical director and patient care staff.

(b) Informing health care providers about documentation, maintenance, and release of information requirements in this manual, JCAHO standards, and local guidance.

(c) Managing medical records personnel.

(d) Developing and conducting the medical records QA program as part of the PAD QA program and documenting participation in the program.

(e) Developing local guidance about medical records with input from appropriate administrative and clinical staff for approval by the medical records committee.

(f) Serving as a member of the medical records committee.

(g) Working closely with all staff members involved with medical records to include admissions, transcription, QA, tumor registry, and ward and clinic administrative staff. Some or all of these staff members may be under the supervision of the Head, MRB.

(h) Organizing and conducting training programs.

(i) Encouraging and maintaining professional certification status for self and supervised staff members.

(j) Protecting the medical records and medical information from loss, defacement, tampering, use, or removal by unauthorized individuals.

(7) Health care providers are responsible for:

(a) Ensuring accurate and complete medical record documentation of all services rendered to patients, and complying with applicable medical records guidelines. Documentation must adequately address current medical, administrative, and legal requirements.

(b) Ensuring proper identification information is entered on various forms.

(c) Promptly returning medical records to the MRB.

(d) Refraining from unauthorized removal of medical records from the MRB or MTF.

(e) Protecting the medical records and medical information from loss, defacement, tampering, use, or removal by unauthorized individuals.

(f) Jointly supporting efforts to maintain quality medical records with the medical records staff, the medical records QA and utilization review committees, and QA functions conducted by individual practitioners and clinical services and departments.

(g) Instructing and monitoring documentation by staff participating in MTF training programs with emphasis on the quality and promptness of documentation and review and cosigning of medical record entries made by trainees.

(8) Ancillary and support personnel must:

(a) Follow guidance on the handling of medical records.

(b) Refrain from unauthorized removal of medical records from the MRB or MTF.

(c) Protect medical records and medical information from loss, defacement, tampering, or use by unauthorized individuals.

(9) Each MTF will establish an MRC to assess the quality of medical care documentation as well as the procedures developed for their establishment, maintenance, and disposition. The MRC will also monitor the adequacy of MTF resources and the environment for medical record functions. The MRC will base their appraisal on the assessment of whether the requirements of Navy directives, JCAHO standards, and local instructions have been met. Measures to correct these deficiencies and followups will be documented in transcribed minutes. The frequency of meetings and the functions of the MRC will be detailed in the MTF's QA plan. The MRC will meet at least quarterly and should include medical records, patient administration, medical, surgical, and nursing staff. The medical records review function is an oversight function of the ECMS, per BUMEDINST 6010.13 series.

(10) Beneficiaries must:

(a) Provide complete and accurate information for the documentation of the history and symptoms of the present illness in the medical record. This includes documentation of care received from civilian sources.

(b) Assure that the medical record documentation remains available for care and administrative purposes. Self-maintenance of medical records is prohibited. See section VI and chapter 23.

(c) Protect their medical records and those of others from loss, defacement, tampering, or use by unauthorized individuals.

**16-12**

**Joint Commission  
on Accreditation  
of Healthcare  
Organizations  
(JCAHO)**

(1) The JCAHO establishes minimum requirements for establishing and maintaining medical records for MTFs seeking JCAHO accreditation. These standards are published yearly in The Accreditation Manual for Hospitals and The Ambulatory Health Care Standards Manual. The principal JCAHO standards that apply to medical records are:

(a) The MTF maintains medical records that are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information, including statistical data.

(b) The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, and accurately document the course and results.

(c) Medical records are confidential, secure, current, authenticated, legible, and complete.

(d) The medical records department is provided with adequate direction, staffing, and facilities to perform all required functions.

(e) The role of medical records personnel in the MTF's overall QA program and in committee functions is defined.

## Section II

# Basic Information That Applies To All Medical Records

Article	Page
16-13	16-13
16-14	16-18
16-15	16-19
16-16	16-21
16-17	16-21
16-18	16-22
16-19	16-23
16-20	16-24
16-21	16-26

## 16-13

### Preparation of Medical Record Folders

#### (1) *HREC Folders*

(a) Prepare a new HREC folder upon initial entry of a member into the Regular or Reserve naval service. A separate dental folder is prepared at the time of the first dental visit.

(b) For individuals who have had prior service and have been discharged, order their HREC and DREC from the National Personnel Records Center, Military Personnel Records (Attn: Navy Liaison), 9700 Page Boulevard, St. Louis, MO 63132-5100. When ordering the records, use only the DD 877, Request for Medical/Dental Records.

(c) When a midshipman or enlisted member is appointed to commissioned or warrant grade, the existing

HREC shall be continued in use. The activity having custody of the record at the time of acceptance of appointment shall:

(1) Make necessary entries to indicate the new grade.

(2) Prepare summary information entries on SF 600 and NAVMED 6150/4 to include date, place, and grade to which appointed.

(d) The HREC shall be opened by the activity executing the enlistment contract upon original enlistment in the naval service. An exception to this are those members who are enlisted or inducted and ordered to immediate active duty at a recruit training MTF. In these instances the HREC will be opened by the naval training center or Marine Corps (MARCORPS) recruit depot, as appropriate.

(e) In all these instances, the original SF 88 and SF 93 shall be attached to the enlistment contract and forwarded with other entrance documents to the Bureau of Naval Personnel (BUPERS) or the Commandant of the Marine Corps (CMC). Copies of the SF 88 and SF 93 shall be

forwarded to the appropriate naval training center or recruit depot to be incorporated into the member's HREC.

(2) **EMF Folders.** Prepare a blue EMF folder upon entry of an employee into the Federal civil service. Additional requirements mandated by the Occupational Safety and Health Act (OSHA) must be followed. For these reasons, the records of active duty members and FCSEs are handled and often maintained separately.

(3) **Dual Status.** When an FCSE is also an eligible beneficiary via another status (i.e., retiree or dependent), the EMF (containing occupational health and work related medical data) must be maintained separately from medical data obtained under the other beneficiary status. A copy of information (e.g., cross-index) from the EMF should be placed in the OREC to ensure proper medical care. Both records should be cross-indexed, following article 16-15, to clearly identify two separate records on the same person. A note should be placed on the NAVMED 6150/20 in both records to ensure this is understood.

(4) **Occupational Health Data.** All occupational health data must be maintained in the HREC per the Navy Occupational Safety and Health (NAVOSH) Program Manual for Forces Afloat (OPNAVINST 5100.19 series), and the NAVOSH Program Manual (OPNAVINST 5100.23 series).

(5) **Active Duty Members Separating From The Service And Continuing To Receive Care.** When an active duty member separates from the military service and continues to receive care from the military health care system, a copy of the HREC is made and a new record folder is prepared and identified as an OREC, for retention at the MTF. These documents will be stamped **DUPLICATE RECORD**, placed in a new record jacket, and the forms arranged in the order of forms prescribed for HRECs. Additional medical documentation will be placed in the same order required for the OREC. The original HREC is sent to the servicing PSD or PSA, which in turn sends it to the Naval Reserve Personnel Center (NRPC), New Orleans, LA; it is subsequently retired to the National Personnel Records Center (NPRC) in St. Louis, MO.

(6) **OREC Folders.** Prepare an OREC folder for every nonactive duty individual who comes for the first time to an MTF for care, or is reporting into a command with a sponsor, at the MTF or facility under contract with the Navy to provide emergency or outpatient care.

(7) **IREC Folders.** An IREC is opened each time that a patient is admitted to an MTF for care, and closed soon after the patient is discharged or transferred. It is reopened only after a patient is readmitted, for the same, similar, or related diagnosis, within 24 hours of being discharged. A copy of specific information (see article 16-25) from the IREC should be placed in the HREC or OREC, or transferred with the patient, to ensure proper medical care.

(8) **Replacement of Record Jackets.** Replace folders when the existing jackets are damaged or when deterioration has reached the point of near illegibility. Destroy the old folder following replacement. Follow the sample NAVMED 6150/10-19 shown in articles 16-13(12) through 16-13(15) as a general guide when preparing the folder.

(9) **General Rules**

(a) Do not permanently alter NAVMED 6150/10-19 folders by stamp, tape, or other means without prior approval of BUMED, except as authorized by this chapter. Patient and command identification and bar code labels may be used. They must have a durable adhesive which does not easily peel off.

(b) Medical records kept at Navy facilities should be in Navy folders (NAVMED 6150/10-19).

(c) Do not use locally developed folders instead of NAVMED 6150/10-19 folders.

(d) Do not use local forms in place of higher echelon forms. Locally developed forms must be approved for use by the medical records committee before being placed in the records folders.

(10) **Cross-Servicing**

(a) **Policy.** The other uniformed services have established records for their beneficiaries. Cross-servicing of medical records is intended. When Army, Navy, and Air Force procedures differ, Navy custodians comply with Navy instructions. Similarly, Army and Air Force custodians of medical records of Navy beneficiaries follow their procedures.

(b) **When Other Uniformed Services Personnel Are:**

(1) Attached to a Navy MTF for primary medical or dental care. The Navy assumes custody of their medical records and services the records. As a rule the HREC and OREC received from an Army or Air Force MTF can be interfiled with Navy records. Replace such folders with NAVMED 6150/10-19 series only if color and blocking does not permit interfiling. If the Army or Air Force does not permit filing on two sides, Navy forms may be interfiled with similar Army and Air Force forms to prevent a new folder from being made.

(2) Treated at Navy MTFs on a temporary basis. Request their HRECs or ORECs if necessary for treatment. After treatment, return the record with new information included. If the HREC is not available, forward records of treatment to the member's duty station for insertion into their medical records. If the current duty station is unknown and cannot be determined using the Automated Quality of Care Evaluation Support System (AQCESS), CHCS, or DEERS, take the following action:

(a) **For U.S. Air Force Members,** send the loose documentation or records to: Headquarters, Air Force Office of Medical Support (HQ ATOMS), Patient Ad-

ministration Division (SGSB), Brook Air Force Base, TX 78235-5000.

(b) **For U.S. Army Members**, send a list with names and SSNs to the appropriate address, requesting the current duty station, as follows:

(1) **Enlisted**. Army Worldwide Locator, U.S. Army Enlisted Records and Evaluation Center, Fort Benjamin Harrison, IN 46249-5301.

(2) **Officers**. Commander, PERSCOM, Attn: TAPC-MSR, 200 Stovall Street, Alexandria, VA 22332-0002.

(c) **Navy or Marine Corps Personnel Treated at Army or Air Force Facilities**

(1) Navy MTF personnel must forward Navy HRECs to Army or Air Force medical officers when members of the naval service are attached for primary medical or dental care to Army or Air Force facilities, or when records are required for treatment.

(2) Army and Air Force health care treatment forms may be filed in Navy HRECs and ORECs.

(3) If the HREC is not available, treatment records should be forwarded to the member's duty station for insertion into the HREC.

(4) When active duty Coast Guard personnel are discharged from a Navy MTF following a period of hospitalization, insert a copy of the signed narrative summary into the HREC and return it to the unit or station where the member is assigned. If the HREC is not available, furnish the copy of the narrative summary, to the unit or station where the member is assigned, for insertion into the HREC. In either instance, furnish a copy of the narrative summary to: Commandant, (G-KMA/63) U.S. Coast Guard, Washington, DC 20590.

(d) **United States Public Health Service (USPHS) or National Oceanic and Atmospheric Administration (NOAA) Officers**

(1) **Active Duty Members**

(a) **Inpatient Care**. Upon discharge, forward a copy of the NAVMED 6300/5, the SF 502, and the SF 516, if applicable, to the following address as follows:

(1) U.S. Public Health Service, Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4-35, Rockville, MD 20857-0435.

(2) National Oceanic and Atmospheric Administration, Commissioned Personnel Center, 11400 Rockville Pike, Room 108, Rockville, MD 20852-3004.

(b) **Outpatient Care**. If the officer's HREC is maintained at the MTF, place documentation of care (SF 600, etc.) into the HREC. If the officer's HREC is not main-

tained at the MTF, forward the documentation of care to the address at 16-13(10)(d)(1)(a) above.

(2) **Dependents**. Place documentation of care in patient's OREC. If no OREC is available, either forward the documentation to the MTF servicing their OREC, or establish a record per section III.

(e) **Nonactive Duty Members and Dependents**. Forward a copy of the narrative summary to the patient's primary medical record. If the primary MTF holding the record is unknown, follow the procedures for military members of the same service, except as specified above.

(11) **Folder Selection**. Select a NAVMED 6150/10-19 series according to the last two digits (primary group) of the applicable social security number (SSN).

(a) Determine the applicable SSN as follows:

<b>If patient is a</b> . . . . .	<b>Use the SSN of</b>
Military member . . . . .	Member
Dependent . . . . .	His or her sponsor
Employee . . . . .	Employee
Retired military . . . . .	Retired military
Civilian medical emergency . . . . .	Patient
Other . . . . .	See 16-13(11)(b)

(b) Patients without SSNs (e.g., foreign military and their dependents, foreign persons who are Secretary of the Navy designees, etc.)

(1) Assign a pseudo SSN as follows: 800 for the first three digits, the year, month, day of birth (i.e., 800-YY-MM-DD) for the remaining six digits.

(2) For foreign military use the military member's birthdate for all family members.

(3) Dependents of persons assigned pseudo SSNs are assigned the sponsor's pseudo SSN, accompanied by the appropriate family member prefix (FMP).

(4) When two patients are admitted with the same birth date, the first three digits of the SSN change to 801 to 899, respectively for the second through tenth persons.

(5) Maintain a log of pseudo SSNs assigned. An example of a pseudo SSN is: 800-50-0118.

(6) Some foreign military may already have a pseudo SSN assigned to them (on a driver's license, student ID, etc.). This number may be used as their SSN for medical records identification purposes.

(12) Select the correct color folder as shown below. The color of the folder represents the last two digits (the primary group) of the patient's SSN as follows:

Primary Group	Folder Color	NAVMED Number	Stock Number
00-09	Orange	6150/10	0105-LF-206-1550
10-19	Green	6150/11	0105-LF-206-1555
20-29	Yellow	6150/12	0105-LF-206-1560
30-39	Gray	6150/13	0105-LF-206-1565
40-49	Tan	6150/14	0105-LF-206-1570
50-59	Blue	6150/15	0105-LF-206-1575
60-69	White	6150/16	0105-LF-206-1580
70-79	Almond	6150/17	0105-LF-206-1585
80-89	Pink	6150/18	0105-LF-206-1590
90-99	Red	6150/19	0105-LF-206-1595

(13) **Ordering.** The medical record folders (jackets) are available from the Navy Supply System.

(14) **Completion of Information on the Inside and Outside of the Folder.**

(a) **Outside Front of the Folder.** Make all handwritten entries with a black permanent marker.

(b) **Numbering.** Enter the patient's FMP at the top of the back leaf of the folder in the first two spaces provided. Do not attempt to use the DEERS Dependent Suffix (DDS) code listed in the DEERS terminal. The DDS code is a computer generated number which must not be confused as an FMP. The FMP is used to show the beneficiary's relationship to the sponsor.

(c) Determine FMP using the following table:

Relationship to Sponsor Family Member Prefix (FMP)	
Sponsor . . . . .	20
Children of Sponsor . . . . .	01-19
(First child registered	
01, second child 02, etc.)	
Spouse of Sponsor . . . . .	30-39
(First Spouse 30, second spouse 31, etc.)	
Mother, Stepmother . . . . .	40-44
Father, Stepfather . . . . .	45-49
Mother-in-law . . . . .	50-54
Father-in-law . . . . .	55-59
Other authorized dependents . . . . .	60-69
Beneficiary authorized by statute . . . . .	90-95
(i.e., children of former service women,	
or of dependent daughters, SECNAV	
designees, etc.)	
Civilian emergencies . . . . .	98
All others not elsewhere classified . . . . .	99
(Foreign nationals, including foreign military, etc.)	

**Notes**

1. The spouse of a deceased sponsor will continue to use the sponsor's SSN. If the sponsor had no SSN, use the sponsor's military serial or service number preceded by leading zeros to complete a 9-digit number.

2. See BUMEDINST 6300.3 series for additional guidance about the assignment of FMPs.

(d) **Social Security Number (SSN)**

(1) Enter the SSN of the patient's sponsor in the remaining eight blank spaces. The second to the last digit of the SSN is preprinted on the jacket. See article 16-13(11)(a) for determination of appropriate SSN.

(2) Black out the 1/2 inch square block along the right side of the right edge of the back leaf of the folder which contains the same digit as the last digit of the applicable SSN.

**Note:**

Facilities wishing to identify the folder as belonging to an individual in a special duty program (Personnel Reliability Program (PRP), asbestos, etc.) should use red tape instead of a black marker for this purpose.

(e) **Patient's Name**

(1) If handwritten: print the last name, first name, and middle initial of the patient in the upper right corner. Indicate no middle name by the abbreviation NMN. If the member uses initials instead of first or middle names, show this by enclosing the initials in quotation marks (e.g., "J"C"). Indicate JR, SR, III, following the member's middle name, or in the absence of a middle name, the first name.

(2) The name may be imprinted on a self-adhesive label and attached to the jacket in the patient's identification box.

(f) **Special categories of records** (e.g., records of personnel assigned to special duty or medical surveillance programs) shall be identified by stamping or printing appropriate entries on the lower portion of the imprinted patient identification label. When an imprinted label is not used, a small label with the appropriate stamped or printed entry shall be affixed to the jacket cover, within the patient's identification box, immediately below the line on which the member's name is printed. If there is sufficient space to accommodate numerous categories, they may be neatly listed below the patient identification box. The above procedure for identifying special record categories shall be used to annotate the HRECs of all flag and general officers (i.e., 0-7, and above) with the phrase **FLAG OFFICER** or **GENERAL OFFICER**, as appropriate, in the lower portion of the patient's identification box.

(g) **Alert.** Immediately below the name, indicate in the alert box whether the patient has sensitivities or allergies by entering an X in the appropriate boxes, in permanent black ink. If none, leave this blank. Alerts for items required by other BUMEDINSTs must be included. For example, NAVMED P-5055 requires the outside of the HREC for those in the Radiation Health Program be labeled Termination Radiation Medical Examination Required. Medical records of civilian employees, containing occupational health data, must be clearly identified as Occupational Health, retain 30 years after termination of employment. All medical records containing insulation or asbestos-related documents must be clearly marked **ASBESTOS**. See SECNAVINST 5212.10 series.

(h) **Record Category.** To the left of the alert box, indicate the record category by entering an X in the box marked OUTPATIENT (MILITARY HEALTH); OUTPATIENT (ALL OTHERS); INPATIENT (ALL CATEGORIES). Attach

1/2 inch tape to the record category tape block on the right edge of the folder. Use red tape for military HRECs, black for ORECs, green tape for IRECs, dark blue tape for military dental records and yellow tape for other dental records.

(i) **Patient Service and Status.** Annotate the status of the sponsor and the relationship the patient has to the sponsor in the lower portion of the record category block on the front of the record jacket. Immediately below the record category box, indicate the sponsor's branch of military service by entering an X in the appropriate box. If the sponsor is not an Army, Navy, Air Force, or Marine Corps member, leave these boxes blank. Enter an X in the OTHER CATEGORIES box and write the sponsor's service on the line provided (e.g., for a Public Health Service member enter PUBLIC HEALTH SERVICE, for a Coast Guard member enter COAST GUARD). If patient is a dependent or is retired, indicate this by writing an X in the OTHER CATEGORIES box and entering the patient's status on the line as in illustration 2 at the end of this section.

(j) **Record Retirement Block**

(1) (Nonactive duty only) For nonmilitary records, mark through the current year. This shows the latest year of treatment and is used to determine the retirement date for individual records. The record should be retired 2 years after the calendar year date of last treatment. As the patient returns for ambulatory treatment and evaluation in subsequent years, black out the box for the appropriate year.

(2) The following facilities, with extensive clinical and research training programs may maintain selected ORECs for up to 5 years after the calendar year date of last treatment: National Naval Medical Center, Bethesda, MD; Naval Medical Center, Oakland, CA; Naval Medical Center, Portsmouth, VA; and Naval Medical Center, San Diego, CA.

(3) Other facilities wanting to maintain ORECs longer than 2 years past the required disposition period should submit a written request to the Chief, Bureau of Medicine and Surgery, Attention: MED-335.

(4) As the patient returns for outpatient treatment and evaluation in subsequent years, black out the box for the appropriate year.

(k) **Retirement Year Tape (RET YR TAPE).** For ORECs affix the appropriate record retirement tape color to the block indicating the anticipated retirement year for the medical record or fill in space with colored marker. Use a 1/2 inch wide, colored, pressure sensitive strip of tape. Place the tape around the edge of the folder (front to back) at the RET. YR. TAPE block. Retirement tape colors are indicated as follows:

Date of Last Treatment (Calendar Year)	Color Tape For Jacket
1993, 1999, 2005 . . . . .	Yellow
1994, 2000, 2006 . . . . .	White
1995, 2001, 2007 . . . . .	Green
1996, 2002, 2008 . . . . .	Red
1997, 2003, 2009 . . . . .	Blue
1998, 2004, 2010 . . . . .	Black

Following patient visits for treatment or evaluation in subsequent years, change the tape to the appropriate colored retirement tape.

(l) **Annual Verification Code (HREC only).** For military members, mark through the current year after verification is complete. This shows the latest year the HREC was verified. See article 16-23(6) for an explanation of annual HREC verification.

(m) **Grade, Rate, or Title.** In pencil, in the block below patient's name, indicate the patient's grade or rate for military and retired military, and preferred title for non-military. If a retired military prefers to be called by a title (e.g., Doctor) other than their military grade or rate, indicate the preferred title in the same box and underscore the preferred title.

(n) **Bar Code.** For those facilities having bar coding capabilities, the bar code label will indicate the patient's FMP, SSN, type of medical record, and the volume number. Affix the label to the front of the record jacket under the ALERT box. See illustration 4. If the barcode is part of the patient identification label (such as produced by the Composite Health Care System (CHCS) computers) then this label should be placed in the patient identification box.

(o) **Labels.** The optional use of a self-adhesive label with the name of the MTF, ship or other units having custodial responsibility for the record is authorized. This label may be produced by CHCS, other electronic means, typed, stamped or neatly printed. Ship or MTF logos are permitted as long as the necessary patient identifying information is not obscured.

(1) The label may not exceed 15/16 inches wide and 3 1/2 inches long. Labels should be affixed to the lower right hand corner, below name block, of the medical record.

(2) When the record is permanently transferred to another MTF, do not change to a new folder just because of the label. Use a blank label or the current MTF's label to cover the existing one. This should be done by the MTF transferring the record before giving it to the individual or mailing it to the gaining MTF.

(3) If a specialty clinic, such as family advocacy, or obstetrics, has a waiver to maintain their own records, they may show their clinic on the same label as the one identifying the MTF.



(p) **Inside Front Cover.** Complete the information in this section in pencil so that it can be changed as the patient moves from one duty station to another. If a computer-generated form is used for the information required, it may be temporarily affixed to the inside cover of the record jacket. The following information will be documented. Complete this information and keep it current.

(1) Date of Arrival. Enter the date sponsor arrived at present duty station.

(2) Projected Departure Date. Enter the date sponsor is projected to rotate to a new duty station, if applicable.

(3) Home Address. Enter the patient's local home address.

(4) Telephone Number (line 2). Enter the patient's local home telephone number (and daytime telephone number, if different).

(5) Sponsor's Duty Station. Enter the sponsor's current duty station, if applicable.

(6) Telephone Number (line 3). Enter the sponsor's telephone number at current duty station, if applicable.

(7) The patient's current address, telephone number, and sponsor's SSN should be verified during each visit to the MTF or DTF, for ease in locating the patient.

## 16-14

### Preparation of the Patient Treatment Identification Card

(1) Emboss plastic identification medical cards when patients first arrive for care at their assigned primary MTF or DTF, to clearly imprint consistent, complete, information on medical record forms where a box is provided for imprinting. Clearly spell out the name of the MTF that holds the patient's record. Do not use abbreviations of command names (e.g., NHO or WRAMC).

(a) **Members Assigned to Ships or Other MTFs.** When a patient arrives for care at an MTF, other than their primary MTF, prepare an embossed medical card to identify the MTF or ship holding the medical record. Two cards may be embossed at the discretion of the MTF, DTF, or ship CDR, CO, or OIC. In this case, one card should be placed on the top, left side of the medical record, and the other card given to the patient to carry on his or her personage. If current, use this card onboard ships (with the capability) to imprint identification data on medical forms

for crewmembers. The following information should be embossed:

(1) Full name (Last, First, Middle).

(2) FMP + SSN.

(3) Date of birth (YY-MM-DD): (i.e., 60-JUL-15).

(4) Sex of patient ( F or M).

(5) Name of ship.

(6) Duty and home phone numbers (with area code).

(b) **Outpatients.** The following minimum information should be embossed on each card:

(1) Full name (Last, First, Middle).

(2) FMP + SSN.

(3) Date of birth (YY-MM-DD).

(4) Sex of patient ( F or M).

(5) Sponsor ( self or first and last name, if another person).

(6) Sponsor's Agency or Military Service: (USN, USNR, USMC, USA, USAF, USCG, USAR, USPHS, Civilian, etc.).

(7) Patient's pay grade or title: (O-6, O2, E7, E2, Mr., Mrs., etc.).

(8) MTF maintaining medical record: (e.g., NH Camp Pendleton, etc.).

(c) **Inpatients.** Emboss each medical card when patients are admitted and when infants are born. Use the medical cards to imprint patient identification (ID) bands and noncomputerized forms where a box is provided for imprinting. The following minimum information should be embossed on each card:

(1) Register number.

(2) Date of admission (DD-MMM-YY): (i.e., 02-MAR-90).

(3) FMP + SSN.

(4) Name of MTF providing care.

(5) Date of birth (YY-MM-DD).

(6) Sex of patient ( F or M).

(7) Full name (Last, First, Middle).

(d) **Newborns.** Add the following information for newborns.

(1) Mother's register number.

(2) Sex of newborn\* ( Girl or Boy).

(\*Leave blank in the case of ambiguous genitalia.)

(3) Mother's full name.

(2) Commands should coordinate with local MTFs to allow for the common use of embossed patient medical cards. Outpatient medical cards may be kept in the OREC or HREC. Punch two holes in the top of the card with a standard two-hole punch. File on top of the left hand side of the folder.

**16-15****Documentation  
in the Medical  
Record**

(1) **Handwritten Entries.** Ensure handwritten entries are legible and recorded in black or blue-black ink.

(2) **Content**

(a) **Patient Identification Data.** Accurate and complete documentation of patient identification data on medical record forms is critical to ensure the documents are placed in the correct patient's record. Use the patient medical card to imprint all forms where space is provided for imprinting. Automated forms should provide the minimum information listed for medical cards. Complete all blank identification spaces on the forms. For outpatients, include the primary care MTF (MTF holding the patient's medical record), or ship, and the patient's home and work telephone numbers.

(b) **Documentation of Visits.** For each visit enter the following information in the patient's health or OREC.

(1) Date. A complete date must be on every page of the medical record. This is true even for forms which are back to front, using the three-letter abbreviation for the month on all dates, e.g., 13 Nov 94.

(2) MTF Name. Name of hospital, ship, clinic, or unit.

(3) Clinical department or service.

(4) HP's name, grade, or rate, profession (for example, physical Therapist (PT), DDS, or MD or corps, and SSN).

(5) Chief complaint or purpose of visit, including if the purpose of the visit is job related.

(6) Objective findings.

(7) Diagnosis or medical impression.

(8) Studies ordered and results, such as laboratory or x-ray studies.

(9) Therapies administered.

(10) Disposition, recommendations, and instructions to patient.

(11) Signatures or initials of practitioners.

(3) **Occupational Illnesses and Injuries**

(a) Document all medical care of active duty and civilian employees relating to occupational health, including if the purpose is job related.

(b) OSHA defines occupational health data, as related to the health status of an individual, which is made or maintained by a physician, nurse, or other health care personnel. See article 16-23 for sequence of forms.

(c) Occupational health uses standard authorized forms as well as forms specific to occupational health. File occupational health-related test results and forms from all

health care providers including those generated outside the MTF in the EMF or HREC.

(d) Health care professionals providing occupational health evaluations should be familiar with the appropriate OSHA regulations. NEHC TM-90-1, Occupational Medicine Field Operations Manual, is a source of basic information for the occupational health care providers.

(e) Examinations and recordkeeping requirements for stressors are mandated by OSHA and Navy instructions and contained in NEHC TM-91-5, Medical Surveillance Procedures Manual and Medical Matrix.

(f) Do not transcribe or summarize medical consultations, evaluations, and reports as errors may result. The original report is important for medico-legal purposes.

(g) Final determinations and any abnormalities identified as a result of the medical evaluation must be noted on the appropriate examination form with the patient informed of the abnormalities and their implications.

(h) Documentation of proper followup is also necessary, regardless of whether the followup is provided by the Navy, other uniformed services, or private medical services.

(i) For purpose of record keeping, medical surveillance program (MSP) refers to any program where medical evaluation is provided on a scheduled basis for personnel exposed to chemical, biological, or physical stressors. A physician's written opinion is required for several medical surveillance programs. NEHC TM-91-5 contains sample forms and identifies the programs requiring these written documents.

(j) One copy must be filed in the EMF or HREC with another copy for the supervisor of the employee and a third copy for the employee.

(4) **Computer-Generated Forms**

(a) Filing of automated and computerized medical reports in the medical record is authorized. Examples of such reports are electrocardiograms (EKGs), cardiac care unit or intensive care unit (CCU/ICU) vital sign monitoring records, scans, and laboratory test results. File in the medical record with reports (standard forms (SFs), Department of Defense (DDs), and Navy forms) to which they relate (e.g., EKG and cardiac monitoring with SF 520; and laboratory test results with SF 545).

(b) Mount undersize reports, such as EKG strips, on the form designated for mounting the specific report (such as the SF 545). If no form has been designated for mounting, use a blank sheet of paper.

(c) Ensure that the undersized reports and the page on which they are mounted include complete patient and MTF identification.

(d) Computer-generated forms satisfying the basic requirements for medical records forms design which fol-

low are authorized for use in Medical Department activities' medical records.

(1) Forms Analysis and Design, published in 1980 by the General Services Administration, is the primary resource for the design and analysis of military medical record forms. This reference is supplemented by guidelines provided for Department of Defense (DoD) and NAVMED forms.

(2) Higher echelon forms shall be used to the fullest extent. Every effort shall be used to avoid partial or complete duplication of higher echelon forms.

(3) Facsimile forms generated by Navy Occupational Health Information Management System (NOHIMS) are authorized for filing in the medical records.

(4) Coordinate forms development with the local medical records committee (MRC) and all military commands involved.

(5) Local automated clinical forms developed for a specific purpose must be approved by the MRC, records committee, forms control committee, and the ECMS at fixed MTFs and DTFs, and by the senior medical department representative on ship.

(6) Data elements must comply with the guidelines of the JCAHO and other applicable accrediting or approving agencies; if applicable to the MTF.

(7) To the extent possible, use standard data elements approved by the ECMS based on current clinical standards of care.

(8) Computer-generated test result forms should have specific spaces identified for laboratory personnel to authenticate the test results and the ordering HP to initial, thus verifying that they have seen the results before filing in the medical record.

(9) *Abnormal results must be verified.* MTFs must establish written local guidance for handling and documenting, in the medical record, tests which exceed the normal values established in the laboratory or reflect abnormal findings, as well as expeditious notification of the patient.

(5) **Overprints.** Overprinting is permitted at the local level, subject to approval by the MTF MRC, forms control committee, and the ECMS. Overprints must conform to the guidelines detailed in SECNAVINST 5213.10 series, Department of the Navy Forms Management Program.

(a) Only permanent information (e.g., MTF address and other stable data) may be overprinted. Do not use for changeable data (e.g., patient name and address).

(b) Information must be consistent with the intent of the form.

(c) Do not alter the design of the original form.

(d) Do not use local form numbers on higher echelon forms.

(e) Do not use overprints to record nonmedical information.

(f) Overprinting must be made on forms currently in stock or on forms purchased through the Federal Supply System stock points. Overprinted forms locally reproduced on plain paper are prohibited.

(6) **Changes.** Submit requests for changes to the text or construction of higher echelon forms to BUMED (MED-913) for review and processing.

(7) **Signatures.** All entries must be authenticated following the JCAHO AMH. All HPs sign the parts of the medical record that are their responsibility as delineated by local guidance. Signatures must be identifiable. HP signatures are accompanied by typed, stamped, or printed HP identification data immediately below the signature. Local guidance dictates the form and content, but include the following as a minimum: the signer's name, grade, profession or corps (e.g., MD or MC), and SSN.

(8) **Countersignatures.** Local MTFs must establish policies to determine what forms, reports, or orders attending physicians must sign. The medical records committee or QA committee should also consider including time frames when a signature must be affixed. On ships and deployable units without a physician, the senior medical department representative countersigns sick call entries completed by junior hospital corpsmen.

(9) **Dating Entries.** Date each medical record entry. The format for dating handwritten entries is: DD-*MMM*-*YY*. Spell out the first three letters of the month.

(10) **Use (or Practice) of:**

(a) **Rubber Stamps.** May be used below HP signatures to document complete provider ID. Local guidance dictates the content, following the direction of the JCAHO AMH. Use of signature stamps is strictly prohibited.

(b) **Peel Off Labels.** Use only for bar code labels, patient and command identification labels, and alert labels.

(c) **Facsimile Signatures.** Refers to a signature stamp or a signature on a telefaxed document. Use signatures on telefaxed documents only in emergencies, with the original provided as soon as possible.

(d) **Electronic Signatures.** Electronic signatures are approved only for use with computerized systems providing for a signature at the end of a computer-generated report or entry. Use is restricted to the person whose signature is being electronically produced.

(e) **Copying (Transcription) of Laboratory and Other Data.** Civilian hospital forms are approved for filing in medical records, do not transcribe this information. File medical information in the medical record in its original format. Copying of human immunodeficiency virus (HIV) data are an exception. HPs transcribe results of HIV test-

ing on the NAVMED 6000/2, (Chronological Record of HIV Testing) form.

(f) **Abbreviations and Symbols.** Each MTF will develop a list of acceptable abbreviations and symbols from current medical dictionaries and the Patient Administration Handbook (NAVMED P-5127). No abbreviation or symbol is to have more than one meaning and the list should be updated at least every 2 years. The list and revisions must be approved by the medical staff and MRC.

(1) Do not use abbreviations or symbols to record the final diagnoses.

(2) Abbreviations and symbols are permitted elsewhere in the medical record where they do not hamper communication between practitioners.

(g) **HIV Positive Diagnoses.** Record positive HIV results on the NAVMED 6000/2 and the NAVMED 6150/20 in the HREC and OREC. Also record positive results on the SF 601 (Health Record-Immunization Record), and the SF 603 (Health Record-Dental Record) in the dental record. **Do not** record an HIV-positive diagnosis on the outside of the medical record folder.

(11) **Recording of Diagnoses and Procedures For Coding Purposes.** Physicians should record diagnoses and procedures in terminology that is consistent with current coding guidelines whenever possible. Where records are coded, inconsistencies should be resolved with the concerned medical staff members before the codes are documented for indexing and statistical purposes.

(12) **Coding of Diagnoses and Procedures**

(a) Where applicable, code ORECs and IRECs to optimize accuracy and completeness of medical data. Coding must be based on thorough medical record analysis. Coding exclusively from the cover sheet or the NAVMED 6150/20 is prohibited.

(b) Code all inpatient medical records within 30 days after discharge to avoid delinquent records. Ensure all codes are accurately entered in the CHCS system data record and the record is closed within 30 days after discharge of the patient.

(13) **Attestation Statement.** The attestation statement in an IREC must be signed by the attending HP to verify the diagnoses and procedures coded. This is the last step before an IREC is considered complete and ready to archive.

## 16-16

### DoD Civilian External Peer Review (CEPR) Program

(1) Since 1986, DoD has contracted with a civilian agency to evaluate the quality of patient care rendered by physicians in fixed military MTFs. These determinations are based on review and evaluation of completed, coded inpatient medical records 90 days after discharge.

(2) MTFs qualifying for accreditation by JCAHO must have IRECs coded and completed within 30 days after discharge. All fixed MTFs are expected to have at least the required percentage of records ready for review within 90 days.

## 16-17

### Maintenance

(1) The terminal digit filing system (TDFS) is used to file HRECs, ORECs, EMFs, IRECs, and x-ray films. The TDFS allows for equal expansion of files. Records may be filed in alphabetical order, by patients' last names, in files housing 200 or fewer records. Records of deployable units and schools may be maintained in a separate file of the MRB.

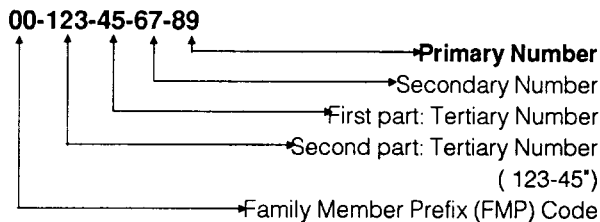
# 16-18 Filing Guidelines and Equipment

(1) **SSN Number Groups.** The nine digits of the SSN are divided into three number groups for ease in reading. This reduces the chance of transposing numbers.

(a) For example, the SSN 123-45-6789 is visually grouped and read from right to left as follows:

Primary Group	Second Group	Third Group
89	67	123-45

(b) Illustration and nomenclature of family member prefix (FMP) and social security numbers (SSNs) as read in terminal digit fashion:



(c) **FMP.** Within a family, file records first by SSN, then in numerical order by FMP (e.g., 01 (first dependent child); 20 (active duty member); then 30 (spouse); etc.).

(2) **Maintaining Files**

(a) **Terminal Digit Filing System (TDFS)**

(1) File medical record by SSN, according to a terminal digit, color-coded and blocked filing system. Under this system, the central files are divided into 100 approximately equal sections, which are identified by a maximum of 100 file guides bearing the 100 primary numbers, 00 consecutively through 99.

(a) Each of these 100 sections contain all records whose terminal digits (last two numbers) correspond to the section's primary number. For example, every record with the SSN ending in 53 is filed in section 53.

(b) Within each of these 100 sections, folders are filed in numerical sequence according to their secondary numbers. The secondary number is the pair of digits immediately to the left of the primary number.

(2) Centralized files having records based upon more than 200 SSNs, or a file of more than 200 records, may need to use the *tertiary (third) number* in filing.

(3) In a *properly* developed and maintained terminal digit, color-coded and blocked filing system, it is almost impossible to misfile a record. A folder misfiled with

respect to the left digit of its primary number, for example a 45 that has been inserted among the 55's will attract attention because of its different folder color. A folder misfiled with respect to the right digit of its primary number, for example a 45 that has been inserted among the 42's causes a break in the diagonal pattern formed by the blocking within a color group.

(b) Authorized Exemptions from the Requirements of the TDFS.

(1) Facilities or files with fewer than 200 medical records, military and non-military combined, may maintain their records in alphabetical sequence. However, the records must be kept in naval medical records jackets.

(2) Separate files on flight personnel and other special categories of personnel:

(a) At bases from which organizations are often transferred as units, records may be filed by organization. This also applies to Army and Air Force records.

(b) Flight surgeons are specifically authorized to maintain separate files of records on flying personnel, missile crew members, air traffic control personnel, and weapons controllers. However, they must ensure that a person's record contains all pertinent treatment.

(c) If a base conducts a school, or has a very high rate of turnover, the MTF commander may recommend that the unit of assignment keep these records. Records for individual cases are then withdrawn as required. The commanding officer or officer in charge of a DTF or Head, Dental Department, may make a similar recommendation for dental health records through the MTF commander.

(3) **Numerical Index Guides.** Index guides may be used in the terminal digit-SSN filing system so that folders and forms can be located quickly.

(4) **Visual File Controls (Folder Colors and Number Scales).** In the TDFS, NAVMED 6150/10-19 folders appear as distinct color groups with the taped digits of the folder number scales forming a stair-step pattern within each of the 100 file sections (i.e., 88 to 99). Where file cabinets are used, the number scales on the top left margin of the folders also form bars with the stair-step pattern running vertically. Misfiled folders are easily detected by breaks in the pattern and SSN terminal digits. Number scales on the top margin serve as an aid in sorting folders and in carrying folders in file trucks.

(5) **Pulling Records.** When a patient comes to the emergency room or clinic for service, get the SSN of the person through whom eligibility is established. Go to the section of the file corresponding to the last two digits of this SSN. The desired record may now be located by name or tertiary number and FMP. When the record is removed from the file, file a properly completed charge-out guide in its place. If this is the first clinic visit for this pa-

tient during this calendar year, mark through the year in the table on the right side of the medical record jacket, using a black pen or black felt-tip marker.

(6) **Cross-Index Files.** A cross-index file must be available, whether automated or manual, to access specific medical records in file. The two main types of indices described below will be kept for this purpose:

(a) **Patient Index (Nominal Index or Locator File).** Establish a patient's index (alphabetic cross-reference), to help determine the record jacket number, if given only the patient's name. Manual systems may be used in MTFs lacking access to computer generated indices. Keep backup tapes for computer generated or computer stored indices.

(b) **Manual Systems.** The following minimum data must be recorded: Patient's full name (last, first, middle), patient's family prefix code and sponsor's SSN, and register number (for inpatients). Additional identifying data (e.g., patient's birth date and sex, and the sponsor's grade or rate, name, and branch of service) may be included on the locator card, but position below the patient's name and folder identification number. Examples of patient index cards are:

**Examples**

SMITH, Elaine Frances 20-123-45-6724 20 Jul 55 F HM1 USN
---

SMITH, John Calvin, Jr. 30-123-45-6724 13 Jun 50 M HM1 Elaine Frances Smith
--

File patient index cards in standard 3x5 inch card file cabinets.

(7) **Loaning Records to Clinics.** When a record custodian loans a record to a clinic, a charge-out guide must be filed in its place. If the clinic, in turn, loans the record to another clinic, the first clinic must notify the record section, in writing, so the location of the record can be changed on the charge-out guide.

(8) **Adding Documents.** Documents are added to the records immediately after they are prepared by local personnel or received from other medical facilities. Documents received while the record is charged out are temporarily placed in the charge-out guide that is filed in the place of the record until it is returned.

(9) **Withdrawing Documents.** When material in a medical record is particularly relevant to further treatment of a person as an inpatient, the material may be withdrawn and inserted in the IREC. The withdrawals are noted on an SF 600. For example, *21 Feb 94, Consultation Sheet dated 2 Jan 93 withdrawn for IREC on admission to the hospital for partial gastrectomy. Robert O. Bridge, LT, MC.*

**16-19**

**Illegible or Contaminated Medical Records**

(1) **Individual Illegible Medical Records.** Duplicate medical record forms whenever they approach a state of illegibility or deterioration or become contaminated, and the future use or value as permanent records is endangered.

(a) The duplicate forms must be a like reproduction of the original as much as possible. Prominently enter the designation **DUPLICATE RECORD** on the front of the file folder above **TREATMENT RECORD** when the entire contents of a medical record is duplicated.

(b) When only a part of the medical record is duplicated, identify the individual forms as DUPLICATE at the bottom of each form.

(c) Document the circumstances necessitating duplication and the date completed in a note on an SF 600.

(d) Microfiche all forms replaced by duplicate forms in an envelope for protection and preservation and make the envelope a permanent part of the medical record. On the front of the envelope, record the identifying data required by article 16-14 and list the contents of the original records. Mark the envelope, record *Original Health (Outpatient or Inpatient) Records - Permanent* and file at the bottom on the right side of the medical record.

(e) If microfilming capability is not available to the MTF, the original forms (except contaminated) will be placed inside a plain envelope for protection and preservation and made a permanent part of the medical record. On front of this envelope, record the identifying data required by article 16-13. Mark the envelope **Original Medical Records - Permanent** and file as the bottom form on the right side of the medical record jacket.

(2) **Large Numbers of Contaminated, Illegible, or Damaged Records Unsuitable for Long-Term Storage**

(a) Stress to all medical-records personnel the importance of appropriate storage procedures to prevent contamination (e.g., mold or mildew) and other severe damage.

(b) For contaminated medical records or medical records found to be unsuitable for the required long-term storage at the NPRC, the following procedures apply:

(1) NAVMEDCOMINST 5600.2 series is the primary guideline for converting Medical Department records to microform.

(2) Petition the Chief, Bureau of Medicine and Surgery (MED-335) for permission to microfilm, using an SF 115 (Request for Records Disposition Authority), per NAVMEDCOMINST 5600.2 series. Provide supporting

documentation on the numbers and cubic feet of medical records involved, the state of the records, causes for the records not being suitable for required storage, and measures taken to prevent recurrence.

(3) Records Eligible for Retirement. When granting permission to microfilm, BUMED will contact the Department of Veterans Affairs (DVA) and NPRC about forwarding the microfilmed copy of records.

(4) Medical records administrators (MRAs) and supervisors must seek environmental health consultation on related health hazards and precautions necessary for personnel handling contaminated medical records. Follow standards established as the result of such medical consultation for Government personnel, and include them in the request for proposal if a contract is used.

(5) Make an effort to remove surface stains from the documents without further damaging the paper to achieve the clearest possible copies. The Preservation Department, National Archives, should be contacted for guidance on proper cleaning procedures. The address is: National Archives; Preservation, Policy and Services Division (NPP); Washington, DC 20408.

(6) As the pages to be microfilmed are numbered, prepare laboratory reports layered on SF 545s (Laboratory Report Display) and radiology reports layered on SF 519s (Radiologic Consultation Requests/Reports). Government or contractor personnel must:

(a) Number each laboratory and radiology report with the page number of the SF 545 or SF 519, respectively, plus a letter of the alphabet (e.g., 28-A, 28-B, 28-C, etc.).

(b) Mount each report, which will not fit layered on the SF 545, sequentially on plain white, numbered sheets of paper.

(c) Place the sheets, in numerical order, within the medical record to be filmed.

(7) If a contractor is used, contracts must include the statement:

The Government will provide a series of (number) individual medical records, with pages numbered sequentially in the order in which they are to be filmed, each clearly marked with patient's name and social security number. Microfiche records are to be returned as (number) microfilmed records, each one (or more, if needed) on a 4-inch by 6-inch microfiche, with pages sequenced as numbered by the Government. Patient identification will be included on each microfiche per NAVMEDCOMINST 5600.2 series. The patient's name will appear at the top left of each microfiche and the social security number listed at the top right of the microfiche. If a patient's medical record contains more than 98 images, the 97th image will be the last on the first microfiche. The 98th image will contain a target: Continued on the Next Fiche.

Where there is more than one fiche per patient, the microfiches will be numbered *1 of 2, 2 of 2, etc.*

(8) Complete microfilming under the film quality standards of NAVMEDCOMINST 5600.2 series or 36 Code

of Federal Regulations, chapter XII, part 1230, 7-188 ed., whichever is more stringent.

(9) Whether contractor or in-house microfilmer, maintain complete, accurate records of the filming process.

(10) After the contaminated medical records are microfilmed, inspect at least 10 percent or at least 10 microfiche (whichever is more) for quality. If the microfiche meets the quality standards, then petition the local medical records committee for permission to destroy the contaminated records.

(11) Have the contaminated records safely destroyed by burning under the guidance of the environmental health officer.

(12) Document action taken in the MTF's MRC minutes and in the log book used to document medical treatment records retired to NPRC.

(13) When retiring records, notify DVA and NPRC that the microfiche records are being forwarded, enclose a copy of the correspondence with BUMED. Forward the microfiche records after receiving a response from DVA and NPRC.

(14) Confirm that all submitted microfiches have been cleared and stored by DVA and NPRC.

## 16-20

## Retirement and Disposal

(1) Combine the member's health, dental, and personnel records no later than 2 working days before transfer or retirement, to assure that all records are accounted for, before the member leaves the area. Retire and dispose of Navy and Marine Corps medical records as follows:

(a) Prior to 31 January 1994, the original HRECs (medical and dental) records of personnel who retired, were retired to the National Personnel Records Center, (Military Personnel Records), 9700 Page Avenue Boulevard, St. Louis, MO 63132-5100; Reserve Personnel Center, 4400 Dauphine Street, New Orleans, LA 70149-7800; and Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS 66211-1408.

(b) Retire military health (medical and dental) records of individuals who retired or separated after 31 January 1994 to the Department of Veterans Affairs, Service Medical Records Center, P.O. Box 150950, St. Louis, MO 63115-8950. The records are stored and disposed of following SECNAVINST 5212.5 series. Routine microfilming of health (medical and dental) records and destruction of

the original records is prohibited. Separating activities will forward closed Navy HRECs to the DVA Service Medical Records Center, St. Louis, MO. For the following categories of individuals:

(1) USN/USNR members released from active duty, after serving on active duty over 29 consecutive days (including 1 year recall, active duty for special work, and active duty for training).

(2) USN/USNR members discharged from the Naval service (including members of the Selected, Ready, and Standby Reserve).

(3) USN/USNR retired members (including transfer to the Fleet and Retired Reserve, permanent disability retired list (PDRL), and temporary disability retired list (TDRL)).

(4) Deceased Navy members, if the body has been positively identified. If the body has not been positively identified, the HREC will accompany the body until identification is made. The activity responsible for identifying the body will forward the HREC to the DVA when the HREC is no longer required.

(c) The Naval Reserve Personnel Center, 4400 Dauphine Street, New Orleans, LA 70149-7800, will maintain HRECs for the following categories of individuals:

(1) Members of the Standby Reserve.

(2) Members of the Individual Ready Reserve (IRR).

(3) USNR personnel transferred from inactive duty training status to the IRR or Standby Reserve.

(4) Volunteer training unit (VTU) members transferred to the individual ready reserve (IRR) or Standby Reserve.

(d) For Marines:

(1) When Marines are being processed for discharge or release from active duty, their HREC will be closed out by the maintaining MTF and delivered to the command element responsible for separation processing.

(2) Military health (medical and dental) records of active duty members and members of the Marine Corps Standby Reserve IRR and USMCR personnel transferred from inactive duty status and VTU members to the IRR or standby reserve will be maintained by the Marine Corps Reserve Center, 10950 El Monte, Overland Park, KS 66211-1408.

(3) Final disposition of HRECs for Marines who are transferred to the TDRL, die on active duty, are declared deserters, confined in Federal prisons, or released or transferred from the regular component to an USMCR unit will be per the Marine Corps Separation Manual (MARCORSEPMAN).

(e) HRECs for Navy personnel who have been declared deserters will be maintained, along with the service

record and dental record, by the Bureau of Naval Personnel, Washington, DC.

(f) Requests for health treatment records (HTR) should be addressed to the appropriate HTR maintenance activity.

(g) An additional copy of the separation physical examination and report of medical history will be filed in the medical record by naval MTFs and Medical Department representatives before delivery of the medical record to the command maintaining the member's service record.

(h) The DVA will screen HRECs upon receipt. In those cases where the DD-214 indicates that the Marine was transferred to the Marine Corps Reserve Support Command (MCRSC), or where a memorandum in the HREC indicates the Marine has remaining obligated service, the DVA will make a copy of the HREC for their use and, within 5 days, will forward the original HREC to the MCRSC. MCRSC will maintain the record until the Marine is no longer a member of the IRR and will return the original record to the DVA.

(2) Unusual disposal issues (i.e., base closures, emergency conditions, etc.) can be addressed to the Navy liaison officer at the NPRC. The address is: Navy Liaison Officer, National Personnel Records Center, Military Personnel Records, General Services Administration, 9700 Page Boulevard, St. Louis, MO 63132-5200. The telephone number is: (314) 538-3132 or DSN 892-3132.

(3) Records and x-rays not meeting the disposition instructions in SECNAVINST 5212.5 series will be returned to the sender at the expense of the sender. The sender will then properly prepare the records for archiving and will pay all shipping charges to return the records to DVA and NPRC.

(4) When records arrive at DVA and NPRC which are contaminated, damaged, or deteriorated to a point that threatens their future use, or ability to be properly archived or destroyed, the originating MTF or sender will pay to either:

(a) **Option 1:** Ship the record back to the originating MTF or command. The sender will be financially responsible for having the records microfiched. The microfiche will be shipped to NPRC. Disposal of the original documents will be performed as detailed in section II, article 16-19 of this manual.

(b) **Option 2:** The sender will pay all costs associated with a contract to ship, microfiche and dispose of the records as detailed in section II, article 16-19.

(c) **Option 3:** The sender will coordinate with a naval MTF nearest the DVA and NPRC to take action as detailed in section II, article 16-19, and will pay all required shipping charges, and all other costs associated with microfiching and disposing of the records.



(5) The sender will closely coordinate with the naval liaison at DVA and NPRC to resolve these problems within 3 months of notification by DVA and NPRC.

(6) Disposition of EMFs. Refer to the Federal Personnel Manual. X-ray films of naval civilian employees are to be forwarded with the EMF when the employee makes an inter- or intra-agency transfer within the Federal government. Chest x-ray must be original films.

## 16-21

### Stray or Lost Records or Forms

(1) The complete health (medical and dental) record will be forwarded to the DVA, NRPC, or BUPERS as detailed in article 16-19 above. Prior to forwarding to PSD, the cognizant MTF will ensure the original and one copy of the separation physical examination is included in the HREC. The PSDs will screen the records prior to transfer, to ensure the HREC is complete.

(2) In the event the member's HREC has been lost or is otherwise unaccounted for, an administrative remarks (page 13) entry, documenting the circumstances, shall be made in the service record prior to transfer to DVA, NRPC, and BUPERS.

(3) Separation physicals must be forwarded to the supporting personnel offices or PSD prior to the date of separation.

(4) When records or loose documents are found on a member who has been discharged from the service, or a nonactive duty individual who is no longer eligible for care in an MTF, the MTF will prepare a list in SSN order, as well as a cover or transmittal letter, and forward it to DVA, NRPC, or BUPERS. A courtesy telephone call to NPRC, Navy Liaison, prior to shipment will assist in facilitating the resolution of this situation. Stray or loose medical records or documents forwarded to NPRC, NRPC, BUPERS, or BUMED without prior notice, and without a cover letter will be returned to the sender for proper disposition.

(5) When HRECs, ORECs, or loose forms, belonging to members or their dependents are found, after the sponsor has transferred to a new duty station, follow the procedure detailed below to locate the primary treating MTF for members and dependents by determining the new duty station of the sponsor. Determine the new duty station address via the MTF's medical record chargeout system. See section II. If the subsequent duty station is not recorded, or the information is outdated, take the following steps:

#### (a) For Navy Members

(1) Check the Defense Enrollment Eligibility and Reporting System (DEERS) or other appropriate automated system, if available.

(2) Contact the personnel support detachment (PSD) for assistance. Many detachments have BI-DEX files or access to worldwide locators. If the PSD is unable to assist, send an alphabetized listing of the records (do not send the records or forms) to Bureau of Naval Personnel, PERS-036, Attn: Navy Worldwide Locator Service, Washington, DC 20370-5000. Include this information on the alphabetical listing: members' name, SSN, and grade or rate. In the letter of transmittal, request a return notification of actual location of the record or permanent duty station of each member listed.

(3) If the member has separated, send the record to the separating activity for forwarding to DVA, NRPC, or BUPERS to be combined with the retired HREC. If the separating activity is unable to assist, forward an alphabetized list to the Bureau of Naval Personnel, PERS-036, Attn: Worldwide Locator, Washington, DC 20370-5000. The office will be able to advise you as to whether any of the members on the list have completed their service obligation and if their medical records have been sent to DVA, NRPC, or BUPERS.

#### (b) For USMC Members

(1) Contact the unit administrative office or the base worldwide locator for assistance. If unable to locate the member, then see article 16-20(1)(a) through (c).

(2) Each Marine Corps base has a worldwide locator. If this search is negative, then send the record to the Office of the Commandant, U.S. Marine Corps, Arlington, VA 22214.

(6) When an active duty member's record or loose documents are found, it will be forwarded to the servicing MTF.

(7) When a separated or retired member's records or forms are found, it will be forwarded to the servicing PSD with a cover letter stating the reason the record or forms were not included in the record. If these records or forms are not forwarded with a cover letter, then they will be returned to the sender for disposition.

(8) Lost HRECs or ORECs. When a medical record is lost or destroyed, the cognizant custodian will open a replacement HREC or OREC. Prominently enter **REPLACEMENT** on the jacket and on all forms replaced. Document a synopsis of the circumstances requiring a replacement and date carried out on the replacement SF 600. If the missing record is located, insert the additional information, or entries contained in the replacement record, into the original record. Do not maintain replacement copies after the primary record has been located.

There is no article 16-22.

## Section III

# Basic Types of Medical Records

Article		Page
16-23	Health Records	16-27
16-24	Outpatient Records	16-32
16-25	Inpatient Records	16-33

## 16-23 Health Records

(1) **Policy.** This section discusses the policies and procedures pertaining to active duty HRECs. Additional details, about the content of these records, are in section VI.

(a) Prepare HRECs for all Navy and Marine Corps military personnel, including active duty, Reserve component personnel, and midshipmen of the Naval Academy. When personnel of the other uniformed services are treated in a Navy MTF, the Navy MTF or DTF is responsible for the appropriate documentation and maintenance of the HRECs. See articles 16-14 and 16-20 for policy on maintaining nonnaval medical records.

(b) Establish an HREC consisting of a NAVMED 6150/10-19 folder containing, as a minimum, the following forms: left side, NAVMED 6150/20, SF 601, SF 545, OPNAV 5211/9, SF 88, SF 93, NAVMED 6150/4, and DD 2005; right-side, SF 600. Use of section dividers is permitted.

(c) These forms will be assembled in top-to-bottom sequence.

(d) Prepare a second NAVMED 6150/10-19 (dental folder) containing: left side, OPNAV 5211/9 and NAVMED 6600/3; and right-side, SF 603, per chapter 6. See chapter 6 for a detailed listing of forms for dental records. See article 16-30 for discussion of the dental record.

(e) **Inactive Reservists.** When inactive reservists are recalled to active duty and their HRECs are not re-

ceived at their duty station, request their records from the appropriate source, as follows:

(1) **For Navy members:**

Naval Reserve Personnel Center (NRPC)  
4400 Dauphine Street  
New Orleans, LA 70149-7800

(2) **For Marine Corps members:**

Marine Corps Reserve Support Center  
10950 El Monte  
Overland Park, KS 66211

(f) Members with prior service who were discharged prior to 31 January 1994 request their medical records from:

National Personnel Records Center (NPRC)  
Military Personnel Records, GSA  
700 Page Boulevard  
St. Louis, MO 63132-5200

(g) Members with prior service who were discharged after 31 January 1994 request their medical records from:

Department of Veterans Affairs (DVA)  
Service Medical Records Center  
P.O. Box 150950  
St. Louis, MO 63115-8950

(h) **Officers.** Recruiting offices open an HREC at the time of acceptance of appointment for individuals appointed from civilian life and forward the record to the initial place of active duty.

(i) **Midshipmen or Enlisted Members** Appointed to commissioned officer or warrant officer grade. Continue use of the existing HREC. Personnel at the activity having

custody of the HREC at the time of acceptance of the appointment:

(1) Make necessary entries to indicate the new grade and the designator or military occupational specialty (MOS).

(2) Prepare summary information entries on an SF 600 and NAVMED 6150/4 to include date, place, and grade to which member was appointed.

(j) **Naval Academy Midshipmen, Officer Candidates, and Student Officers.**

(1) Personnel at the Naval Academy will open HRECs for civilian candidates selected for appointment.

(2) Prepare HRECs for Naval Reserve Officer Training Corps (NROTC) applicants as follows:

(a) At the time of enrollment, assemble NAVMED 6150/10-19 folders for NROTC applicants containing copies of the SF 88 and SF 93 prepared at the time of enrollment. For United States Naval Academy (USNA), NROTC, Uniformed Services University of Health Sciences (USUHS), or BOOST, these candidates will have Department of Defense Medical Examination Review Board (DoDMERB) physical forms, DD 2351, DD 2492, DD 2480, in addition to or in lieu of the SF 88 and SF 93.

(b) The professor of naval science prepares and includes the SF 600, NAVMED 6150/4, and SF 601 as the need arises.

(c) Complete the NAVMED 6150/10-19 dental folder and original SF 603, at either the time of the pre-commissioning physical exam or the first annual physical examination, whichever occurs first.

(k) **Enlisted Members.** Personnel in the activity executing the original enlistment into the naval service will open the HREC of an enlisted member. An exception is those members who are inducted and ordered to immediate active duty at a recruit training activity. In these instances, the naval training center (NTC) or Marine Corps recruiting station (MCRS) will open the HREC, as appropriate. Forward copies of the SF 88 and SF 93 to the appropriate NTC or recruit depot. Combine these forms with other applicable HREC forms in the member's HREC.

(l) **Reservists.** The Naval Reserve Personnel Center (NRPC), New Orleans, as custodian of the records for inactive Reserve personnel, is responsible for the preparation and maintenance of HRECs of inactive reservists.

(m) **Navy Civilian Employees.** Prepare an employee medical file (EMF) for Navy civilian employees. The EMF contains occupational health data and must be maintained and retained following OSHA (29 CFR 1910.20) for a minimum of 30 years after termination of employment. See NEHC TM-90-1 and NEHC TM-91-5 for more specific information for exceptions to retention periods for some occupational health data.

(1) EMFs and x-ray folders containing insulation or asbestos-related documents must be clearly identified as containing asbestos-related information and must be retired following SECNAVINST 5212.10 and SECNAVINST 5212.5 series until further notice.

(2) X-rays are defined by OSHA as including x-rays taken for the purpose of establishing a baseline or detecting occupational illnesses and must be retained as part of the medical record. See article 16-33 for details of retention, transfer, and retirement of chest x-rays and other x-rays not microfilmed or fitting in the EMF.

(3) The EMF must be retained, transferred, and retired following articles 16-23 (1)(m) and (1)(n). If the x-rays are chest films, do not file these in the retirement folder, the EMF must document where the films are located.

(n) **Retirement of EMFs.** The EMF must be reviewed, transferred, and retired following the Office of Personnel Management (OPM), Federal Personnel Manual (FPM) chapter 293 and OSHA regulations. For transfers of records within the Navy claimancy, OPM transfer and retirement regulations do not apply. A review for order, completeness, and accuracy by medical records personnel is sufficient, with the records, including x-rays, forwarded to the requesting MTF.

(o) **Civilian Employee Transfers and Retirements Outside the Navy Claimancy.** For all transfers and retirements outside the Navy claimancy, compliance with FPM requires use of the SF 66-D (blue) jackets or SF 66-C (orange) jackets, for employees who have worked under more than one personnel system. (For example, Department of Veterans Affairs and Civil Service System.) Within 30 to 120 days after separation, the EMF is reviewed for completeness and accuracy, placed in the blue or orange folder with documents in the order specified in appendix A of FPM Supplement 293-31. The folder is then transferred to the requesting MTF, or retired as required in SECNAVINST 5212.5 series to the National Archives, National Personnel Records Center (Civilian), 111 Winnebago Street, St. Louis, MO 63118. EMFs of foreign civilian employees can be retired to the National Personnel Records Center using the same guidelines as for civil service employees.

(p) **X-rays, other than chest films,** may be microfilmed for retirement. However, all x-rays forwarded with the EMF for retirement must not be larger than 8 1/2 by 11 inches. See article 16-33 for maintenance and retirement of chest films and other x-rays not microfilmed or fitting in the EMF.

(2) **Use of the HREC**

(a) The active duty HREC serves as the unit record for military members. For this reason, the following events are recorded in the HREC:

(1) Document all outpatient care, including occupational health-related evaluations and examinations, whether received in a military or civilian facility, in the HREC. Active duty members have the responsibility and are under obligation to ensure that all care they receive while on active duty is accounted for in the HREC including documentation of care from nonnaval sources.

(2) Place legible and reproducible copies of narrative summaries (SF 502s) and short form (SF 539) admissions, and original medical boards (see article 16-25 for additional guidance) in the HREC.

(3) File documentation of treatment received while in the field, at a fleet hospital, on a ship, in a civilian facility, or in an ambulance in the HREC.

(4) An active duty member may choose to include significant medical history, which occurred prior to entrance into active duty, in their HREC. If the information may have future impact on their health, it should be included on the NAVMED 6150/20.

**(b) Use of the HREC for Outpatient Medical Care**

(1) Routinely make the HREC available to the provider whenever an active duty member seeks medical care. This allows the provider to review the patient's medical history before initiating a treatment plan.

(2) When a patient is to be referred to a provider other than one in the MTF where the record is maintained, the record may be checked out to the patient to be hand-carried. Each MTF must establish a mechanism to ensure that records which are checked out, are returned to the responsible MTF in a reasonable period of time. Patients are not to maintain records outside of the Federal system.

**(c) Use in Inpatient Care**

(1) Normally, the HREC is sent to the MTF when a person is admitted for treatment. When the MTF receives an HREC, the MRA at that MTF ensures the record is accessible to the patient's HP. The attending HP ensures that the major diagnoses and treatments associated with the inpatient stay have been recorded on the NAVMED 6150/20. The MRA will ensure that a copy of the summary of inpatient care, and operation report, if any, are forwarded to the servicing MTF and placed in the HREC before returning to the file.

(2) When a member is released from the MTF and departs without the HREC, the MRA must forward the HREC as follows:

(a) **Members Returned to Duty.** Send the HREC to the record custodian of the MTF that provides the member's outpatient care. If the MTF is not known, send the HREC to the member's unit.

(b) **Members Transferred.** The MRA will contact the member's PSD or PSA to determine the new par-

ent command and forward the HREC to the MTF serving the member's unit. If the member was transferred as a patient to another MTF, the MRA will send the HREC to the PAD at that MTF, specifying whether the patient is inpatient or outpatient.

(c) **Members Transferred to Veterans Administration Medical Centers (VAMCs).** Send a copy of the HREC, a copy of all medical boards, and a copy of the member's IREC pertaining to the current illness to the treating center. Send the original HREC to the MTF having administrative cognizance over the care of the patient.

(d) **Members Separated from Service.** Send the HREC to the military personnel officer handling the separation.

(e) **For Patients on Unauthorized Absence (UA) in Excess of 10 Days.** Send the HREC to the PSD or personnel unit holding the member's service and pay records.

(f) **For Reserve Component Patients Not on Active Duty.** Send HREC to the custodian of the service and pay records.

(3) **Preparation of HREC Folders.** See article 16-13. Dental records are more specifically discussed in chapter 6 of this manual and section V of this chapter.

(4) **Sequence of HREC, OREC, and EMF Forms.** The four-part record described in this article is not yet available for distribution. As an interim measure, continue to use HREC jackets currently available. The four parts of the HREC should be separated by a locally devised divider, with parts one, two, and three on the left side, and part four on the right side. This action will facilitate easy installation of each part when the new jackets become available.

(a) When assembling HRECs or EMFs arrange forms in chronological sequence by date of most recent action. Use of section dividers in the HREC is permitted. Interfile civilian treatment and nonstandard forms with like forms (e.g., file laboratory results from civilian providers with the SF 545s). The sequence of forms for HRECs is printed below:

(b) The forms are divided into four parts:

(1) Part 1. Record of Preventive Medicine and Occupational Health.

(2) Part 2. Record of Medical Care and Treatment.

(3) Part 3. Physical Qualifications.

(4) Part 4. Record of Ancillary Studies, Inpatient Care, and Miscellaneous Forms.

(c) The sequence of forms for all medical records is printed below. The abbreviations in this chart are listed in section VIII of this chapter.

(d) Left Side of HREC Folder (Top to bottom with most current entry on top within group of forms):

Form Number and Title	HREC/EMF	OREC
<b>Left Side - Part 1: Record of Preventive Medicine and Occupational Health</b>		
NAVMED 6150/20, Summary of Care Form (Always top form)	X	X
SF 601, Immunization Record	X	X
NAVMED 6000/2, Chronological Record of HIV Testing	X	
DD 771, Eyewear Prescription	X	X
NAVMED 6490/1, Visual Record	X	X
NAVMED 6470/10, Record of Occupational Exposure To Ionizing Radiation	X	
NAVMED 6470/11, Record of Exposure to Ionizing Radiation from Internally Deposited Radionuclides (Interfile behind 6470/10 with corresponding dosimetry issue period)	X	
DD 2215, Reference Audiogram	X	
DD 2216, Hearing Conservation Data	X	
NAVMED 6224/1, TB Contact/Converter Followup	X	X
NAVMED 6260/5, Asbestos Medical Surveillance Program	X	
DD 2493-1, Asbestos Exposure-Part I, Initial Medical Questionnaire (Attach to correspondence NAVMED 6260/5)	X	
DD 2493-2, Asbestos Exposure-Part II, Periodic Medical Questionnaire	X	
OPNAV 5100/15, Medical Surveillance Questionnaire	X	
Other 5100 Forms-Occupational Health Series Forms	X	
<b>Right Side-Part 2, Section A: Record of Medical Care and Treatment</b>		
NAVPER 5510/1, Record Identifier for Personnel Reliability Program (PRP) (always top form, except for deaths) File all forms below in chronological order with most current form on top, regardless of form number. Be sure to group episodes of care together.	X	X
SF 558, Medical Record-Emergency Care and Treatment Record of Ambulance Care	X	X
SF 600 HREC-Chronological Record of Medical Care (If for outpatient surgery, dictate or document immediately after surgery and file with corresponding SF 516. Otherwise file as exhibited here.)	X	X
SF 513, Medical Record-Consultation Sheet	X	X
DD 2161, Referral For Civilian Medical Care	X	X
<b>Top Forms in Part 2, Section A When Patient is Deceased</b>		
Attestation Sheet	X	X
DD 2064, Certificate of Death	X	X
SF 503, Autopsy Protocol	X	X
SF 523, Authorization for Autopsy	X	X
SF 523A, Disposition of Body	X	X
SF 523B, Authorization For Tissue Donation	X	X
<b>Right Side-Part 2, Section B: Inpatient Care, Ambulatory Surgeries, etc.</b>		
NAVMED 6300/5, Inpatient Admission/Disposition Record (Copy)	X	X
SF 502, Medical Record, Narrative Summary (Copy)	X	X
SF 539, Medical Record-Abbreviated Medical Record (Copy)	X	X
SF 509, Progress Notes	X	X
SF 516, Medical Record-Operation Report (Original for Outpatient Surgery) (Dictate/document immediately after surgery.)	X	X
SF 600 HREC-Chronological Record of Medical Care (Outpatient Surgery: To be dictated immediately after surgery) (File with corresponding SF 516)	X	X
SF 517, Anesthesia	X	X
SF 522, Request for Administration of Anesthesia (file with corresponding SF 517)	X	X
SF 533 Medical Record-Prenatal and Pregnancy (Only for patients not admitted for delivery)	X	X
Civilian Medical Care Notes	X	X
DD 602, Patient Evacuation Tag (staple to current SF 600)	X	X
<b>(e) Right Side of HREC Folder</b>		
<b>Left Side - Part 3: Physical Qualifications, Administrative Forms</b>		
NAVMED 1300/1, Medical and Dental Overseas Screening Review For Active Duty and Dependents	X	X
NAVPER 1300/16, Report of Suitability For Overseas Assignment Parts I, II, and III	X	X
NAVMED 6100/1, Medical Board Report Cover Sheet	X	
NAVMED 6100/2, Medical Board Statement of Patient	X	
NAVMED 6100/3, Medical Board Certificate	X	
NAVMED 6100/5, Abbreviated Temporary Limited Duty	X	
SF 2824C, Physicians Statement for Employee Disability Retirement	X	
SF 47, Physical Fitness Inquiry For Motor Vehicle Operators	X	
SF 78, Certificate of Medical Examination	X	
SF 88, Report of Medical Examination	X	
SF 93, Report of Medical History (file behind corresponding SF 88 or SF 78)	X	
BUMED Waiver Letters with BUPERS Endorsement	X	
NAVMED 6120/1, Competence for Duty Examination	X	

Form Number and Title	HREC/EMF	OREC
NAVMED 6120/2, Officer Physical Examination Special Questionnaire (File in place of SF 93, when used.)	X	
NAVMED 6120/3, Annual Certificate of Physical Condition	X	
NAVMED 6150/2, Special Duty Medical Abstract	X	
NAVMED 6150/4, Abstract of Service and Medical History	X	
NAVJAG 5800/10, Injury Report		X
NAVJAG Report - Investigation to inquire into the circumstances surrounding the injury of (servicemember).	X	
NAVPER 1754/1, Exceptional Family Member (EFM) Program Application	X	X
DD 2569, Third Party Collection Program (see BUMEDINST 7000.7 series for additional guidance)	X	X
Living Will or Medical Power of Attorney	X	X
OPNAV 5211/8, Record of Disclosure, Privacy Act of 1974	X	X
DD 877, Request for Medical/Dental Records	X	X
DD 2005, Privacy Act Statement	X	X
Deoxyribonucleic Acid (DNA) Analysis Sample Pouch	X	
<b>Right Side, Part 4, Record of Ancillary Studies, Therapies, Etc.</b>		
SF 217, Medical Report - Epilepsy	X	X
SF 515, Medical Record-Tissue Examination	X	X
SF 519A, Radiographic Consultation Request/Report	X	X
SF 519B, Medical Record-Radiologic Consultation Request/Report	X	X
SF 519, Medical Record-Radiographic	X	X
SF 518, Medical Record-Blood or Blood Component Transfusion	X	X
SF 520, Medical Record-Electrocardiogram Request	X	X
SF 524, Radiation Therapy	X	X
SF 525, Radiation Therapy Summary	X	X
SF 526, Medical Record-Interstitial/Intercavity Therapy	X	X
SF 527, Group Muscle Strength, Joint ROM, Girth and Length Measurements	X	X
SF 528, Medical Record-Muscle Function By Nerve Distribution: Face, Neck, and Upper Extremity	X	X
SF 529, Medical Record-Muscle Function by Nerve Distribution: Trunk and Lower Extremity	X	X
SF 530, Neurological Examination	X	X
SF 531, Anatomical Figure (May also be filed under a corresponding SF 600, SF 513, etc.)	X	X
SF 541, Medical Record-Gynecologic Cytology	X	X
SF 545, Laboratory Report Display	X	X
SF 546 - 557, Laboratory Reports. (Attach through to SF 545 in chronological order)	X	X
SF 559, Medical Record-Allergen Extract Prescription-New and Refill	X	X
SF 560, Medical Record-Electroencephalogram Request and History	X	X
SF 511, Vital Signs Record	X	X
SF 512, Plotting Chart	X	X
SF 512A, Plotting Chart - Blood Pressure	X	X

(5) Maintenance. See article 16-17.

(6) Verification of HREC

(a) Medical record personnel must verify each HREC annually. Whenever possible, verify the information with the member present. In addition, verify HRECs when a member reports to and detaches from a duty station, and at the time of physical examination.

(b) Review each record, noting any errors or discrepancies, and correct them. Ensure overdue or outstanding medical requirements are reported to the appropriate department for completion (i.e., immunizations). Give special attention to:

(1) Ensure accuracy, completeness, and legibility of all identifying information entered on the HREC folder and HREC forms, including name, SSN, designator or military occupational specialty, date and place of birth, sex, grade, rate, current duty station, and phone number.

(2) Verify blood group and Rh factor and, if applicable, allergies, sensitivities, and PRP status.

(3) Ensure that all appropriate forms are filed in order in the HREC, including SF 600s, completed NAVMED 6150/20, laboratory and radiology reports, and consultation sheets.

(4) Verify that all tests and examinations required in chapters 6 and 15 of this manual have been performed and documented in the HREC.

(5) Verify that the Privacy Act Statement has been signed in the HREC, and any secondary records.

(6) Determine that the patient data blocks indicating current home address and phone number, and date of arrival are up to date and accurate.

(7) Ensure that next of kin information in block 14 of the SF 88, Report of Medical Examination, is up to date and complete.

(8) Write, date, and sign an entry on the current SF 600 to indicate that verification has been done.

(9) Indicate on the front of the member's HREC folder that verification has been completed by blacking out, with a black permanent marker, the numbers for the current year along the right side of the folder.

(10) Never remove medical documentation from a civilian source. Interfile with the SF 600s and other similar forms.

(c) At the end of the calendar year, review the files to find out which records do not have the current year blacked out. Complete verification of the unverified HRECs.

(7) **Yearly Inventory of HRECs.** Each year medical record personnel must inventory records of active duty personnel assigned to your MTF as their primary care MTF. The MRA should obtain a current roster from the PSD for this purpose.

**(8) Closure of HRECs**

(a) General Instructions. Close the HREC when a member:

- (1) Dies.
- (2) Is discharged.
- (3) Resigns.
- (4) Is released from active duty.
- (5) Is retired.
- (6) Is transferred to the Fleet Reserve and released to inactive duty.
- (7) Is declared missing or missing in action.
- (8) Is declared a deserter.
- (9) Is disenrolled from officer candidate or midshipman programs.
- (10) Is declared dead.

**Note.**

HRECs contain health and occupational health documentation and must be maintained and dispositioned following SECNAVINST 5212.5 series or OSHA (29 CFR 1910.20), as appropriate. If x-rays are chest films, or do not fit in the HREC folder, the HREC must document where the films are located.

(b) Record the closing entries on NAVMED 6150/4, Abstract of Service and Medical History. Include the following in the entry:

- (1) Date of separation.
- (2) Title of servicing activity.

(3) Any explanatory circumstances.

(c) Ensure the record is in order, that there are no loose papers, and all identification data is consistent. Ensure all pertinent documents are included.

(d) Deliver the entire HREC, including NAVMED 6150/10-19, except as otherwise provided in the following articles, to the command maintaining the member's service record (no later than the day following separation) for inclusion in and transmittal with the member's service record. If requested by the member, on release, discharge, or retirement, provide a copy of the HREC free of charge.

(e) Ensure the original and a copy of the separation physical examination is included in the HREC prior to delivery to the supporting command.

(f) Ensure that the dental folder is with the HREC.

(9) **Missing or Missing in Action Members.** Whenever a member disappears and the available information is insufficient to warrant an administrative determination of death, enter a summary of the relevant circumstances on the SF 600. Include circumstances about the presumed disappearance of the individual, i.e., missing or missing in action, supported by the available evidence. Close the record and handle as in 16-23(8)(a) above.

**(10) Desertion**

(a) When a member is officially declared a deserter, make an explanatory entry of this fact on the SF 600 and NAVMED 6150/4. Deliver the HREC, including the dental record, to the member's CO for inclusion in and transmittal with the member's service record for both Navy and Marine Corps personnel.

(b) When a deserter is apprehended or surrenders, the CO of the jurisdictional activity must submit a request for the member's records to BUPERS or CMC, as appropriate.

**(11) Discharge or Death**

(a) Upon discharge and immediate reenlistment, retain the entire HREC in the field.

(b) Upon discharge, close the HREC and handle as in articles 16-23(8)(b) through (8)(d) above.

(c) Upon death of the member, make proper closing entries in the HREC, add a copy of the death certificate, and handle as in article 16-23(8)(a) above.

(12) **Discharge of a Member Convicted by Civil Authorities.** When BUPERS or CMC directs discharge of a member convicted by civilian authorities, the member's CO, or the cognizant area coordinator designated by Chief of Naval Operations (CNO) in whose area the member is confined, must make arrangements for the physical examination and report. The physical examination may be conducted and reported by any of the following:

- (a) Medical officer at an MTF or other Federal Government agency.
- (b) Penal institution physician.

(c) In the absence of the above-listed physicians, a certificate signed by the official in charge of the penitentiary about the present state of health of the person to be discharged. File the original SF 88, or the statement received from the prison official, in the HREC and close the HREC, as in articles 16-23(8)(b) through (8)(d) above.

(13) **Release to Inactive Duty.** Close the HREC:

(a) Whenever members of the Reserve components are released from active duty including active duty for training.

(b) On transfer to Naval or Marine Corps Reserve inactive duty from the Regular Navy or Marine Corps.

(c) On transfer to the Fleet Reserve or Fleet Marine Corps Reserve and release to inactive duty, forward the completed HREC as in articles 16-23(8)(b) through (8)(d) above.

(14) **Retirement.** When a member of the naval service is placed on the retired list and released to inactive duty, or on release to inactive duty, close the HREC per article 16-23(8)(c) above. Upon the request of the retiring service member, establish a new OREC. Place a copy of the active duty HREC in a new NAVMED 6150/10-19 folder. Note on an SF 600 in the HREC and the new OREC the date the HREC was closed.

(15) **Disenrollment of Midshipmen or NROTC Members.** When a midshipman's affiliation with the naval service is terminated, close the member's HREC and forward it to the separating activity to join with the service record for retirement. This includes midshipmen who graduate from the Naval Academy, but do not receive commissions. For midshipmen who retain a status in the naval service after disenrollment from the Naval Academy, forward the HREC to the member's prospective CO.

(16) **Terminally Ill Members.** Retained in Naval MTFs After Retirement (Retired/Retained)

(a) When a terminally ill retired/retained member is retired from the service through the Disability Evaluation System, do not close the HREC, but keep it open pending disposition from the MTF.

(b) Make a note on the most current SF 600 to record the date of retirement.

(c) If the patient dies, include a copy of the death certificate and narrative summary and close the HREC per articles 16-23(8)(b) through (8)(d), and forward it to the separating activity.

(17) **Disability Separation or Retirement**

(a) The MTF must send a copy of the HREC of a member, being separated for disability, to the DVA regional office nearest to where the member will be residing. This must go directly from the MTF to the DVA so that the record can be considered as a primary source of evidence in processing a claim for veterans' benefits. A record carried by the member is considered secondary

evidence and will not be used to process a claim. If possible, send the record with the VA 526, Claim for Benefits, so that the regional office can initiate the claim.

(b) Any member who separates from the service and who is eligible for veteran's benefits should be provided a copy of his or her HREC on request. Members should be counseled to request a copy in the event they will make a claim for veteran's benefits in the future. Always offer to send the copy of the record to the DVA regional office for them.

(18) **Interservice Transfer.** On transfer to the Army, Air Force, or other service, in an active duty status, annotate that the member has transferred to their new status (in the U.S. Army, U.S. Air Force, etc.), and give to the member to handcarry to their new duty station.

## 16-24

## Outpatient Records

(1) **General.** These records are established for nonactive duty patients (except Federal Civil Service employees).

(2) **Preparation and Maintenance of OREC Folders.** See articles 16-14, 16-17, and 16-18.

(3) **Sequence of OREC Forms and Personnel Responsible for Completing the Major Forms.** See article 16-23.

(4) **Verification.** Verify each OREC for accuracy per articles 16-14 and 16-23 for nonactive duty beneficiaries, when a patient first checks into an MTF and before retirement of the record. Make an entry on the current SF 600 to document verification, and mark out the year block on the front of the record.

(5) **Retirement of ORECs.** See also article 16-20.

(a) Medical records personnel must conduct an annual review of the outpatient files for retirement.

(b) Retire medical records for patients not receiving services within the past 2 years, or 5 years for teaching facilities, see article 16-20, following SECNAVINST 5212.5 series.

(c) Do not retire records of eligible living members of the family when other members are receiving treatment.

(d) Requests for early retirement of records (such as for MTF closure, or ship decommissioning, etc.) must be made through MED-335 to the National Archives Administration, Washington, DC. Once the request is approved, the MTF or ship will retire records following SECNAVINST 5212.5 series.

(6) **Contract Care Records.** Navy Cares (NAVCARE) clinics are primary care clinics under contract to the Navy to provide medical care to eligible beneficiaries.

(a) For NAVCARE contracts that started in 1993 and after, the medical records which the NAVCARE clinics maintain are the property of the contractor and must be dispositioned following the contractual agreement. For these contracts, disposal of the NAVCARE medical records is the responsibility of the contractor, consistent with applicable State and Federal laws. These records are not to be archived in the NPRC.

(b) The contracts between the NAVCARE clinics and the Navy require that medical record copies be provided to beneficiaries on request. The contractor may collect fees for copying medical records.

(c) Active duty members are required to ensure that if they are seen in a NAVCARE, Primary Care for the Uniformed Services (PRIMUS), or other clinic under contract with the Federal Government, or in any civilian MTF, they place a copy of the documents of treatment they received in their HREC.

(d) Nonactive duty beneficiaries should request copies of treatment records when they receive medical care for a chronic or serious condition. These copies may be placed in their military medical records.

## 16-25

## Inpatient Records

(1) **Preparation of IREC Folders.** See articles 16-13, 16-15, and 16-18.

(2) **Maintenance.** See article 16-17.

(3) **Contents.** Each IREC must contain the minimum information required by JCAHO.

(4) **Standards.** IRECs are completed to ensure they meet the highest standards of completeness, promptness, clinical pertinence, and standards of the JCAHO.

(a) The medical staff, through one of its authorized committees, reviews records to ensure that sufficient information is documented to substantiate the diagnosis, justify the treatment, and warrant the end result. The record must include, at least, pertinent history, physical examination, laboratory reports, progress notes, doctor's orders, and nursing notes. A clinical resume (summary) is required for all patients hospitalized for over 48 hours, except in the circumstances stated in article 16-55.

(b) Naval MTFs qualifying for accreditation by JCAHO must have IRECs coded and completed within 30 days after discharge.

(c) IRECs will be initiated and maintained only for patients physically admitted to the military MTF. IRECs will not be initiated or maintained for patients admitted to civilian medical facilities under external partnership programs, or other contracts outside of the military MTF.

(5) **Sequence of Forms.** The NAVMED 6150/10-19 folder is divided into two sections: left side and right side of the folder. File administrative information on the left side and clinical treatment documentation on the right side of the folder. When the records are received in the MRB for coding and archiving, place forms, within each section, in date order with most current date on the bottom. The local MRC determines how local forms or specialty forms are filed in the inpatient chart. Any exception to the list below is to be approved in the minutes of the MRC. If forms have been automated, they need not be placed on standard forms, but must comply with the guidance of this chapter. Assembly for archiving, with the first form on top, is as follows:



## (a) Left Side of Inpatient Folder

**Form Number and Title**

NAVME 6550/14, Patient Data Base  
 NAVJAG 5890/12, Third Party Liability Claim Form  
 NAVMED 6010/8, Patient Valuables Form  
 NAVMED 6010/9, Baggage Record Card  
 DD 877, Request for Medical/Dental Records  
 OPNAV 5211/9, Record of Disclosure-Privacy Act of 1974  
 DD 2005, Privacy Act Statement-Health Records (signature not required)  
 Living will or medical power of attorney

## (b) Right Side of Inpatient Folder

**Form Number and Title**

NAVME 6300.5, Inpatient Admission/Disposition Record (Cover Sheet)  
 SF 535, Newborn Identification  
 SF 502, Clinical Record-Narrative Summary (Original to IREC; copy to HREC or OREC)  
 SF 539, Abbreviated Medical Record  
 NAVMED 6100/1, Medical Board Report (Used in place of SF 502 if applicable to the case)  
 SF 558, Emergency Care and Treatment Record  
 DD 602, Patient Evacuation Tag (File beneath the applicable SF 502, SF 539, or NAVMED 6010/5)  
 SF 507, Continuation of SF (file with standard form being continued)  
 SF 504, Clinical Record-Privileged History (Part I) (see article 16-47)  
 SF 505, Clinical Record-History (Parts II and III) (see article 16-47)  
 SF 506, Clinical Record-Physical Examination (see article 16-47)  
 SF 508, Doctor's Orders  
 SF 513, Consultation Sheet  
 DD 2161, Referral for Civilian Medical Care  
 SF 509, Doctor's Progress Notes  
 NAVMED 6320/16, Recovery Room Record  
 SF 533, Prenatal and Pregnancy  
 SF 534, Labor  
 SF 516, Operation Report  
 SF 517, Anesthesia  
 SF 522, Request for Administration of Anesthesia and for Performance of Patient, Operational, and Other Procedures and Witness  
 SF 515, Tissue Examination  
 SF 524, Radiation Therapy  
 SF 525, Radiation Therapy Summary  
 SF 526, Interstitial/Intercavity Therapy  
 SF 527, Group Muscle Strength, Joint R.O.M. and Length Measurements  
 SF 528, Muscle and/or Nerve Evaluation - Manual and Electrical: Upper Extremity  
 SF 529, Muscle Function by Nerve Distribution: Trunk and Lower Extremity, Face  
 SF 530, Neurological Examination  
 SF 531, Anatomical Figure  
 SF 741, Eye Consultation  
 SF 521, Dental  
 SF 510, Nursing Notes  
 SF 536, Pediatric Nursing Notes  
 SF 537, Pediatric Graphic Chart  
 SF 538, pediatric  
 NAVMED 6550/12, Patient Profile  
 NAVMED 6550/13, Patient Care Plan  
 NAVMED 6550/72, Nursing Discharge Care Plan  
 SF 511, Vital Signs Record  
 SF 512, Plotting Chart  
 SF 512A, Plotting Chart - Blood Pressure  
 SF 537, Pediatric Graphic Chart  
 DD 792, Twenty-four Hour Patient Intake and Output Worksheet  
 NAVMED 6550/76, Cardiac Arrest Flow Chart  
 SF 545, Laboratory Report Display  
 SF 546-557, Laboratory Reports  
 SF 541, Gynecological Cytology  
 SF 518, Blood or Blood Component Transfusion  
 SF 519, Radiographic Reports  
 SF 519A, Radiographic  
 SF 519B, Radiographic Consultation Request/Report  
 SF 520, Electrocardiographic Record  
 SF 560, Electroencephalogram Request and Summary

**Top Forms When Patient Is Deceased**

NAVME 6300/5, Record of Inpatient Treatment (includes attestation statement)  
 DD 2064, Certificate of Death  
 SF 503, Medical Record-Autopsy Protocol  
 SF 523, Clinical Record-Authorization for Autopsy (not required for active duty members) (Original)  
 SF 523A, Medical Record-Disposition of Body  
 SF 523B, Medical Record-Authorization for Tissue Donation

## (c) Uncomplicated Obstetrical Record

NAVME 6300/5, Inpatient Admission/Disposition Record  
 SF 539, Abbreviated Medical Record  
 SF 508-522, (same as above)  
 SF 534, Labor Record (continue same as above from SF 522)  
 SF 533, Prenatal Record (including entire prenatal record from OB clinic)

## (d) Uncomplicated Newborn Record

NAVME 6300/5, Inpatient Admission/Disposition Record  
 SF 539, Newborn Record (back of SF 539)  
 SF 508, Doctor's Orders  
 SF 510, Nursing Notes  
 SF 545, Laboratory Reports  
 NAVMED 6320/11, Newborn Identification  
 (No form number) Newborn Maturity Rating and Classification

(6) **Transfers.** Attach the medical record that accompanies a patient transferred from another hospital to the bottom of the right side of the receiving MTF's IREC for reference.

(7) **Countersignatures.** The following IREC reports and entries must be countersigned by the attending physician, or when appropriate, by a qualified oral surgeon within 24 hours after they are completed:

(a) Histories and physicals performed by someone other than the senior resident, staff physician, qualified oral surgeon, or certified midwife.

(b) Reports of operations written or dictated by someone other than the primary surgeon.

(c) Narrative summaries written or dictated by someone other than the attending physician, dentist, podiatrist, or midwife in charge of the case.

(d) Physician's telephone or radio orders received and recorded by independent duty corpsmen when ships are underway are exempt from this requirement to gain a countersignature.

(e) Discharge progress notes. Supervisors of house staff members. Each MTF must specify the intervals when the attending HP must document in the IREC their active participation in and supervision of the patient's care. The name of the HP who has overall responsibility for the care of the patient during the current episode must be clearly documented in the IREC and the patient must be made aware of who is the primary physician on their case.

(f) Attestation Statement. The attestation statement in an IREC must be signed by the attending physician to verify the diagnoses and procedures coded. This is the last step before an IREC is considered complete and ready to file.

(8) **Maintenance.** See article 16-17.

(9) **Retirement.** IRECs are normally retired 2 years after the last inpatient discharge from the MTF. The following facilities, with extensive clinical and research training programs, may maintain selected IRECs for 5 years after the patient's last inpatient discharge: National Naval Medical Center, Bethesda, MD; Naval Medical Center, Oakland, CA; Naval Medical Center, Portsmouth, VA; and Naval Medical Center, San Diego, CA. Other Navy MTFs wanting to maintain IRECs longer than 2 years past disposition should submit a written request to the Chief, Bureau of

Medicine and Surgery, Attn: MED-335, 2300 E Street, NW, Washington, DC 20372-5300.

(10) **Completion.** Complete IRECs of discharged patients within 30 days following discharge. This and other guidelines for IREC completion published by JCAHO must be followed. Completion is defined as having all record discrepancies corrected and all necessary forms filed and signed, as required by applicable guidance.

(11) **Verification of Records.** The requirement for annual verification is not applicable to IRECs. IRECs shall be verified for accuracy at the time of receipt for local archiving. At this time, records shall be reviewed for proper identification, filing of forms, and completion of the record

jacket following the requirements of this manual and JCAHO accreditation standards. Any errors or discrepancies noted shall be corrected. A signed, dated entry showing that the verification has been accomplished shall be recorded in the record.

(12) **Retirement of IRECs.** Annually, IRECs must be reviewed for retirement eligibility. Eligible records must be verified for completeness and retired in numerical (TDSSN) order, and must be accompanied by a corresponding alphabetical index (DD 739 or automatic data processing (ADP) listing). Retire all IRECs as directed in paragraph 3 of SSIC 6150 of SECNAVINST 5212.5 series.

# **Section IV**

## **Medical Records for Operational Medical Departments**

<b>Article</b>	<b>Page</b>
16-26 <b>Introduction</b>	16-37
16-27 <b>Responsibilities of the Commanding Officer</b>	16-37
16-28 <b>Basic Requirements of the Fleet Medical Record</b>	16-38

### **16-26**

#### **Introduction**

(1) Summarizes the differences between medical records established in a fixed MTF and medical records established and maintained by deployable units or under combat conditions.

(2) The senior medical officer shall be the custodian of medical records on ships, deployable units, single-billeted isolated shore locations, and branch medical annexes not immediately accessible by the parent MTF (echelon 4 or 5). In locations without a senior medical officer, the senior medical department representative shall be the custodian of medical records. This responsibility may be delegated to a hospital corpsman at the discretion of the CO, depending on the size of the vessel or activity. Where there is no medical department representative, or if the duty destination is not obvious, the HREC shall be kept with the member's service record.

### **16-27**

#### **Responsibilities of the Commanding Officer**

(1) Commanding officers must ensure that medical records are maintained per this chapter within the constraints of their resources and the conditions under which they are operating.

(a) Custody of the medical records may be delegated to the medical records program administrator or medical department representative on a ship or deployable unit.

(b) HRECs must be included in reviews by the immediate superior in command (ISIC) and ADMAT inspections.

(2) JCAHO standards are not applicable to operational medicine. Nevertheless, the quality of the record must be such that care and treatment of patients are in no way compromised.

**16-28****Basic  
Requirements  
of the Fleet  
Medical Record**

(1) **Philosophy.** Medical care delivered in an operational environment is different from the well-controlled environment of a fixed MTF. The mission of an operational environment MTF is to keep Sailors and Marines healthy, save lives, render emergency medical care, stabilize the patient's condition, and transfer the patient to more definitive care.

**(2) Operational Conditions**

(a) Navy Personnel. Maintain HREC's of personnel assigned to ships onboard the ship. Maintain HREC's of personnel not assigned to ships at the MTF nearest their assigned station.

(b) Marine Corps Personnel. Maintain HREC's in the member's battalion aid station, division, or MTF where care is usually given.

(c) Predeployment Record Review. Before each member is deployed determine and document that:

(1) The member is fit for deployment.

(2) The member has medical alert tags for all allergies.

(3) The member's immunizations are up to date and correctly annotated on the SF 601.

(4) The member has a current physical examination, including special duty, (i.e., flight, diving, submarine, etc.) in the HREC.

(5) The member has current occupational medicine monitoring (including audiogram, asbestos monitoring, respiratory protection, etc., as applicable).

(6) If the member requires periodic prescription medication which is not carried on the ship's authorized medical allowance list (AMAL), an adequate supply is obtained for the deployment.

(7) If the member requires corrective lenses a spare pair of lenses is available, and gas mask inserts have been issued.

(d) An HREC entry must be made documenting the results and completion of this records review.

**(3) Health Records**

(a) **Verification.** The HREC shall be verified upon receipt, at the time of physical examination and before transfer to make sure that all required entries are present in the record. HREC's records shall be verified at least annually by the medical department having custody of the record and an appropriate entry shall be made on the SF 600.

(1) Check HREC's quarterly against the pay list or ship's roster to make sure that an HREC is onboard for each military member.

(2) Each patient reporting to sick bay shall have an entry made in his or her HREC on an SF 600. The importance of proper record keeping cannot be overemphasized. It may be of great value to the Government or to a member in establishing entitlement to benefits for a service-connected disability. Entries in the HREC's shall contain the date, name of the ship, complaint, and treatment rendered in the following S.O.A.P. format:

S - SUBJECTIVE COMPLAINT (patient's complaint and history)

O - OBJECTIVE SIGNS (examination findings)

A - ASSESSMENT (diagnosis)

P - PLAN (treatment and disposition)

(3) All signatures in the health record shall be signed in black or blue-black ink. The name, grade or rating, and social security number of the medical department representative making entries in the HREC shall be typed, block-printed, or stamped under the signature.

(a) Stamped facsimile signatures shall not be used on any medical or dental forms in the HREC.

(b) In signing, the individual assumes responsibility for correctness of the entry.

(c) We suggest that a rubber stamp, as in the following example, be procured for medical department personnel to ensure clear entries:

Example: I. M. WELL

HM1 USN 123-45-6789

(4) On ships without dental facilities, the dental records (DREC's) shall be checked quarterly against pay lists or ship's rosters to ensure a DREC is onboard for each military member. Additionally, dental reviews shall be performed by a dental officer to ensure dental record accuracy and dental needs of individual crewmembers.

(b) **Chargeout Control.** Control of HREC's shall follow article 16-10. Additionally, the chargeout form for members transferring from the command will be kept onboard for 1 year and shall list the forwarding address for the individual transferred.

(c) **Abandon Ship.** Make necessary arrangements to salvage the HREC's and DREC's in the event of abandon ship.

**(d) Medical Consultations**

(1) Patients requiring additional consultative services at other medical facilities shall use the SF 513, as described in article 16-50.

(2) A properly completed SF 513 will accompany each patient referred for consultation.

(3) In general, patients shall not be referred to a hospital for consultation with a specialist without first having been seen by a general medical officer except: in emergencies; when a medical officer is not available; or when a delay may jeopardize the welfare of the patient. If operating conditions dictate, direct transfer of the patient, whose medical

emergencies; when a medical officer is not available; or when a delay may jeopardize the welfare of the patient. If operating conditions dictate, direct transfer of the patient, whose medical conditions warrant such action, shall be effected without delay. Patients should be referred for consultation only when the medical history and condition warrants referral.

(4) When medical services are required upon arrival in port, such services may be requested by naval message, or any suitable voice communications.

(e) **The Consultation Sheet.** The request for consultation SF 513, shall include a summary of the patient's history, i.e., condition, complaints, treatment administered to date, results of regime, and any other information that may be of value to the medical officer conducting the consultation.

(f) **Other Information.** X-rays, laboratory reports, or pertinent information should also accompany the patient.

(g) **Cancellation of Appointment.** If the operation schedule of the ship changes or other unforeseen incidents occur whereby appointments for consultations cannot be fulfilled, the appointment shall be canceled quickly and as far in advance as possible.

(h) **Admissions/Discharges**

(1) **Sick List.** Administrative procedures for admitting patients to the Sick List in ships shall follow BUMEDINST 6300.3 series. Each admission shall be documented on a NAVMED 6300/5, Inpatient Admission/Disposition Record, and in the HREC. Clinical charts shall be prepared for each patient admitted and shall contain the forms specified in article 16-25. Upon discharge of the patient from the ward, the narrative summary, SF 502, shall be completed by the attending physician as specified in article 16-45. Place the original in the HREC and a copy in the inpatient record (IREC). All IRECs shall be retained on-board and disposed of according to SECNAVINST 5212.5 series.

(2) **Seriously Ill/Very Seriously List (SI/VS).** Personnel whose illness or injuries are of such severity, as defined in MILPERSMAN 4210100, shall be placed on the SI/VS List and appropriate notification made as required.

(3) **Sick in Quarters (SIQ).** SIQ from shore medical facilities shall be considered a treatment recommendation. The command makes the final disposition.

(4) **Convalescent Leave (CONLV).** Personnel sent on convalescent leave from a naval hospital (NAVHOSP) should be evaluated by an attending physician before returning to duty. CONLV is a recommendation by an attending physician to the command which is considered an adjunct to patient treatment. The command must evaluate each recommendation based on individual case history and operational priorities.

(i) **Referrals for Admission**

(1) **Ships with Inpatient Facilities.** Patients will be admitted and transferred on NAVMED 6300/5, Inpatient Admission/Disposition Record. Clinical charts or abbreviated clinical records, x-rays, and laboratory results as applicable, and HRECs shall be completely documented as specified in article 16-25. IRECs shall be disposed of per SECNAVINST 5212.5 series.

(2) **Ships or Units Without Inpatient Facilities.** Patients requiring hospitalization shall be referred for admission on SF 513, Consultation Sheet. When a patient requires admission to the Sick List while at sea, the disease, injury, or complaint shall be completely documented in the HREC. The HREC shall accompany the patient upon transfer to the inpatient treatment facility.

(j) **Transfer of Patients to Naval Hospitals and Other Federal Facilities.** In general, the transfer of patients from ships or units to a hospital should be effected only upon the recommendation of a medical officer. Ships or units without a medical officer should seek advice from the medical guard ship, dispensary, or other ships before transfer of routine cases to a hospital. In an emergency or when no medical officer is available, direct transfer to the hospital should be accomplished consistent with sound medical judgement and common sense.

(k) **Treatment of Military Personnel in Non-Federal Medical Facilities**

(1) Personnel who require emergency medical treatment while on authorized leave or liberty shall, if practicable, go to the nearest Federal activity in the vicinity.

(2) If Federal facilities are not available, and military personnel receive inpatient medical and dental care from civilian facilities in the United States, the individual concerned shall obtain a copy of medical documentation and provide it to the medical department personnel immediately upon returning to the ship. Bills or charges for civilian medical or dental care shall be turned over to the medical department immediately upon receipt for payment processing per NAVMEDCOMINST 6320.1 series.

(l) **Treatment of Military Personnel OCONUS.** Whenever military personnel receive medical or dental care from non-Federal sources outside the continental limits of the United States (OCONUS), the individual concerned shall obtain a copy of medical documentation and provide it to the medical department personnel immediately upon returning to the ship. If the medical documentation is not in English, the medical department personnel shall make arrangements, as quickly as possible, to have the documents translated. The English translation and the copy of the original documentation shall be placed in the individual's HREC.

(4) **Documentation of care** rendered is important so that the receiving MTF is aware of what was done to the

patient and what treatment regimen is continuing for the patient.

(5) **Deployment.** The HREC and the dental record accompany an active duty member when deployed.

(6) **Medical records,** as we know them in fixed MTFs, are maintained differently under operational conditions.

(a) If patients go on to another level of care, send all original documentation of care with them. The documentation continues until they have reached the first fixed MTF. MTF personnel must place all documentation into the IREC, or the HREC if the patient is treated on an outpatient basis. X-rays will be filed at the MTF which has administrative or medical cognizance of the patient.

(b) If the patient is returned to duty from the fleet MTF, the documentation of care must be placed in the HREC. The forms originated on hospital ships or fleet hospitals are the only original inpatient forms permitted in the HREC.

(7) **Forms**

(a) Use standard forms as much as possible.

(b) Include the MTF's name on each page to identify where the care was rendered.

(c) The standards of documentation detailed in this chapter must be adhered to as much as possible given the level of activity.

(8) **Deceased Personnel**

(a) **Active Duty.** Transfer health and dental records with the remains of the deceased active duty casualties. These records are an important part of the identification process.

(b) **Other Personnel.** Transfer a copy of any medical records with the remains. Retain the original medical records with the MTF. Transfer these records to NPRC, St. Louis when 2 years old.

## Section V Specialty Records

Article	Page
16-29 <b>Purpose</b>	16-41
16-30 <b>Dental Records</b>	16-41
16-31 <b>Family Advocacy Program (FAP) Records</b>	16-42
16-32 <b>Drug and Alcohol Treatment Records</b>	16-44
16-33 <b>Medical X-Ray Film Jackets</b>	16-44
16-34 <b>Adolescent Clinic Records</b>	16-47

### 16-29

#### Purpose

(1) Provides information and guidelines for initiating, maintaining, releasing, and retiring specialty records. A specialty record is established and maintained within an MTF under guidance other than this chapter. Where other guidance is lacking on the topics listed above, it is presented in this section. Personnel involved in these areas must be aware of the laws and directives governing their programs.

### 16-30

#### Dental Records

(1) The **primary guidance** for dental records is chapter 6.

(2) **Custody.** The dental record shall be retained in the custody of the medical or dental officer of the ship or station to which the member is attached for all personnel on active duty. Custody of the dental record for all Reserve personnel not on active duty (i.e., Selected Reserves, and Voluntary Training Unit Personnel) will be maintained by the Reserve medical department representative (MDR) of the cognizant activity (i.e., readiness command, readiness center, Naval and Marine Corps Reserve Centers). Members are not to maintain their own dental records.

(3) **Preparation of Dental Records.** Prepare and order dental record folders per chapter 6 and section II of this chapter.

(a) Prepare a dental record for each military member when entering into the Regular or Reserve naval service.

(b) Prepare a dental record for each nonactive duty patient the first time they receive dental treatment in a naval DTF.

(4) **Maintenance.** Maintain dental records consistent with chapter 6. The dental record is part of a member's HREC, although the dental record is ordinarily filed separately from the HREC.

(5) **Transfer of Dental Record.** Transfer dependent dental records at the time the sponsor is permanently transferred. Maintain nonactive duty dental records in the

catchment area where the patient resides or receives treatment.

(6) **Release of Information and Transferring Record.** See section VI of this chapter.

(7) **Record Retirement.** Prepare dental records for retirement following SECNAVINST 5212.5 series. Forward to the separating activity with the HRECs, personnel, and pay records of members per articles 16-21 and 16-23. Retire dental records of nonactive duty members and dependents as one records group series per SECNAVINST 5212.5 series 2 years after the calendar year in which the patient was last treated. Retire dental records of civilian employees consistent with article 16-30 and chapter 6.

## 16-31 Family Advocacy Program (FAP) Records

(1) **Guidance:** SECNAVINST 1752.3, OPNAVINST 1752.2, and NAVMEDCOMINST 6320.22 series.

(2) **The FAP** is a multifaceted, multi-disciplinary program addressing all aspects of intervention related to maltreatment involving military personnel and their dependents. This intervention involves a coordinated team approach and includes identification, evaluation, treatment and education, case management, and prevention.

(3) **Family Advocacy Representative.** The commander, commanding officer, or officer in charge of an MTF must appoint a full-time social worker as the family advocacy representative (FAR) when the number of new cases referred to the MTF case review subcommittee each month reaches an average of eight for 6 consecutive months at MTFs in CONUS and an average of five each month for a period of 6 consecutive months at MTFs OCONUS. The FAR serves as the custodian of FAP records maintained within the MTF.

(a) There are currently seven sites in which the FAP case management function has been realigned from the MTFs to the family service centers (FSCs). This realignment may occur Navy-wide. In locations that have been realigned, FAP records will be maintained in the FSC as opposed to the MTF. The FAR, located at the MTF or FSC, serves as the custodian of FAP records.

(b) In locations where there is a collateral duty FAR who is not a clinical social worker, the collateral duty FAR serves as the MTF administrative point of contact for incoming FAP cases, but the FAP records are maintained in the FSC by the family advocacy specialist (FAS) who provides the clinical intervention and case management.

(c) Guidance regarding FAP records applies to all FAP records, whether maintained in the MTF or the FSC.

### (4) FAP Records

(a) FAP records are categorized as ancillary (secondary) and specialty records, (whether they are maintained in MTFs or FSCs) although some of the policies applying to FAP records are the exception to those applying to secondary records. See article 16-7.

(b) Establish an FAP case record for each suspected or known victim of abuse. These records will be maintained in NAVMED 6150/00-19 folder. The sponsor's SSN and the person's FMP will be used to identify the record. Open each case in the victim's name and case number. Cross reference all cases by the name of the perpetrator for tracking and screening purposes. If the abuse is by a person who is an eligible beneficiary but not a family member (extrafamilial) and the victim is not an eligible beneficiary, open case in offender's name and case number. Cross reference the extra-familial cases by the names of the victims.

(c) In intrafamilial (within the family) cases, when a status determination of *substantiated* is made, the following one-line entry must be recorded (on the NAVMED 6150/20 and an SF 600) in the HRECs and ORECs of all active duty and dependents in that family: *FAP Case Record activated this date. See FAR.* The purpose of this entry is to alert attending HPs to the fact of FAP involvement. In substantiated extra-familial cases, similar entries must be made only in the victim's record.

(d) When there is no longer FAP case activity in the family, the FAR will make an entry on an SF 600 as well as on the NAVMED 6150/20 indicating the case is closed and why it was closed. Closure can be for any one of three reasons: case is resolved; case is unresolved; or case is closed due to the sponsor being separated from the service. For a resolved case, the statement would read, *FAP case record closed this date, resolved.*

(e) Normally ORECs involving FAP cases are filed in the ORECs department of the MTF. In those circumstances where there is concern that special handling of the record is necessary to secure the record's availability (for medical or evidential reasons), the record may be placed in the confidential records section of the ORECs department. A record jacket with the location of this file should be placed in the proper place in the general records filing system.

### (5) Contents

(a) Contents of the FAP record are in NAVMEDCOMINST 6320.22 series.

(b) Make copies of pertinent medical entries for the FAP record. This includes pertinent medical record review findings and relevant inpatient information.



(c) Psychosocial information should normally be put in the FAP record, not the OREC.

(d) Information relevant to the diagnosis should be placed in the IREC if the victim is hospitalized.

(e) The record may also contain photographs of the injuries of the suspected or known victim. All photos taken should comply with NAVMEDCOMINST 6320.22 series (e.g., each photo should show a card with identifying data visible in the photo).

(f) Place Privacy Act Statement, NAVMED 5211/1, signed by each adult interviewed in the FAP record. Document refusal to sign.

(g) Include a face sheet with all identifying information.

(h) Include all SF 513s relevant to the FAP case.

(i) SF 600s should be used to document all handwritten recordings. Entries should incorporate all contacts including telephone and collateral contact, case staffing, case status determinations, assessments, treatment and education plans, etc.

(j) The original of all DD 2486s, Child/Spouse Incident Report, should be kept in the FAP record.

(k) Include all correspondence sent and received.

(l) Include all other reports (e.g., NIS, police, and civilian therapists) in the FAP record.

**(6) Transfer Procedures**

(a) Do not transfer closed or unsubstantiated cases.

(b) Give the new FAR a *heads up* by telephone. Be sure to identify specific receiving command of service member and the estimated arrival date. Active FAP cases in need of further services should not be transferred to isolated or overseas locations.

(c) Complete DD 2486 transfer report and forward to central registry. Be sure to include the unit identification code (UIC) of the receiving FAR.

(d) Send the original FAP record to new FAR with a cover letter which asks for a receipt. Keep a copy of the FAP record pending receipt of notice of arrival of the original FAP record by the FAR at the new duty station. Make sure the initial DD 2486 is included. Once receipt of notice is returned, destroy the copy of the FAP record. If the case has not been reported to the central registry, state this in the transfer summary. Include a case summary which includes the history of FAP action to date and what remains to be accomplished. The record with cover letter must be forwarded directly to the FAR of the installation to which the sponsor is transferring. FAP case records are not given to individual patients to carry with them.

(e) Keep the record open if other family members are still in the area.

(f) Make an entry in the FAP logbook regarding date and place to which case transferred.

(7) **Closed Case Records.** When a FAP record (substantiated, at risk, or unsubstantiated case) is closed, keep it at the treating MTF for 4 years. If there are subsequent incidents, reopen the case.

**(8) Retirement of Records**

(a) The MTF will retire all closed case records from the last MTF of FAP activity to NPRC, St. Louis, Missouri, as an OREC 4 years following closure of record if there has been no case activity. FARs will coordinate the retirement of FAP records with the MTF MRB. The FAP record is retired through the MRB when they do their annual OREC retirement. Only ORIGINAL FAP records can be retired to NPRC.

(b) In intrafamilial FAP cases with multiple victims, each victim must have a separate color-coded chart with the sponsor's SSN and the FMP for retirement. Make copies of the contents of the record for each victim.

(c) When notified by the ORECs department of accession number under which the file will be retired, enter the accession number in the FAP logbook next to the case entry.

(d) Include a statement in the closing SF 600 entry that, except for MTF or FSC FAP personnel and subpoenas signed by a judge from a court of competent jurisdiction, all requests to NPRC for access to FAP records must be forwarded to BUMED legal (MED-36) for proper disposition. All release of information is guided by the Privacy Act of 1974 as established by SECNAVINST 5211.5 series and the Freedom of Information Act as established by SECNAVINST 5720.42 series.

**(9) Release of Information**

(a) Information regarding FAP cases may only be released to DoD and sanctioned civilian agencies as defined in the SECNAVINST 5720.42 series, SECNAVINST 5211.5 series, and following applicable State and local written policies. Records may be subject to a subpoena when ordered by a judge.

(b) Patients involved in FAP cases normally are not permitted direct access to the FAP case record. Should a patient request a copy of their FAP file, the request should be handled as either a Freedom Of Information Act request or a Privacy Act request per SECNAVINST 5720.42 series or SECNAVINST 5211.5 series.

(c) Before releasing FAP case files, the record must be reviewed by a judge advocate general corps (JAGC) officer to determine whether an exemption applies to the case file and to purge personal third party's information, the release of which would constitute a clearly unwarranted invasion of personal privacy.

(d) Disclosure of documentation contained in the record but originating from a source outside the MTF should not be released without the permission of the originator.

(e) When any disclosure of information is made, the following information must be documented in the FAP case file:

- (1) The date and time of the release.
- (2) The type of information released.
- (3) The reason for making the disclosure.
- (4) The name and address of the recipient of the information.
- (5) The name of the person releasing the information.

## 16-32 Drug and Alcohol Treatment Records

(1) These are medical records initiated and maintained in the Navy's counseling and assistance centers, free-standing alcohol rehabilitation centers (ARCs), and MTF-based alcohol rehabilitation departments.

(2) OPNAVINST 5350.4 series, Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) applies to these records. Drug and alcohol treatment records include both standard forms and specialized forms developed for use within the program.

(3) See section VI for discussion of release of information from the drug and alcohol treatment records.

(4) Defense Investigative Service (DIS) Agents. The following steps must be followed when releasing medical information to DIS Agents:

(a) An appropriately completed DIS Form 40, Alcohol and Drug Abuse Information Release and Consent to Redisclosure, is required for release of ADAPCP records.

(b) An appropriately completed Authority for Release of Information and Records, included in DD 398, Personnel Security Questionnaire, is required for release of HRECs.

(c) An appropriately completed DIS Form 16, Doctor/Patient Release Statement, is required before releasing general records maintained by doctors, hospitals, and other institutions, pertaining to medical or psychiatric examinations or treatment. This form should also be used if the DIS agent desires to interview a physician for evaluation or opinion of the individual's case.

(5) DIS agents are required to provide the appropriate release form before they are provided the requested information.

(6) Additional information may be obtained from DoD Directive 6040.2, Release of Information from Medical Records.

## 16-33

### Medical X-Ray Film Jackets

(1) **General.** This article discusses the establishment, maintenance, transferring, and retirement of folders (jackets) in which radiology films are filed. Unless otherwise directed within this article, x-rays will follow the guidelines established in this manual, SECNAVINST 5212.5 series, and the Federal Personnel Manual, for the establishment, maintenance, filing, safekeeping, storage, release, issuance, accounting, and disposition of medical x-rays.

(2) **Description.** The radiology folders are 14 1/2 x 17 1/2 inches and are color coded for TDSSN filing following the same scheme used for HRECs, ORECs, and IRECs. An x-ray jacket with identifying information printed on both sides will soon be made available. However, NAVMED 6760/0-9 will continue to be used until the current stock is exhausted.

(3) **Preparation of Radiology Folders.** Establish a radiology folder when a patient first reports for a radiology consultation and additional folders (see 16-33(3)(a)(6)) when the initial folder becomes too full to hold additional films. Complete the information on the front of the folder using a permanent black marker.

(a) Select an x-ray jacket by matching the last digit of the x-ray jacket form number to the second to the last digit of the sponsor's SSN. For example, if the sponsor's SSN ends in 62, select form NAVMED 6760/6; if the SSN ends in 12, select form NAVMED 6760/1. Use a felt-tip pen to record information on the x-ray jacket as follows:

(1) Patient's FMP and SSN. Determine the appropriate FMP and which SSN to use per article 16-13. Enter the FMP in the two diamond-shaped boxes preceding the SSN boxes in the upper right corner of the folder. Enter the sponsor's SSN in the nine boxes after the FMP.

(2) Patient's Name. Enter name on the printed line below the SSN. Write the person's grade or preferred title in pencil in parentheses above the name.

(3) Patient's Service and Status. Enter the patient's service and status as indicated in the upper left corner of the jacket.

(4) Date of Birth. Enter the patient's date of birth on the line below the name in DD-MMM-YY order, e.g., 22 Mar 84.

(5) Patient Category. Place an X in the appropriate boxes to indicate whether the patient is military or dependent, the branch of service of the sponsor (if applicable), or to indicate other category. If the patient's category is not 1 of the 3 indicated branches of service,

and the other block is marked, specify category on the line labeled other categories.

(6) Jacket #\_\_\_ of\_\_\_. Determine whether the patient has other x-ray jackets that have been filled before making the entry.

(7) Diagnostic (Teaching) Index Number. Leave blank. This data is to be entered by the radiologist.

(8) X-ray Disposal Schedule Color Tape Code

(a) Tentative disposal dates for x-rays are indicated on forms NAVMED 6760/0-9, by attaching various colored tapes in the box marked COLOR CODE TAPE following the schedule printed on the jacket. Use 1/2 inch wide, bright colored, pressure sensitive, cellophane tape in strips approximately 1 inch long. Attach the tape in the space provided and extend the tape around the edge of the jacket to the back.

(b) The following is a provisional schedule for disposal of x-rays in the terminal digit file. The color coded tape sequence is repeated at 6-year intervals.

Date of X-Ray (Calendar Year)	Color Tape* for Jacket	Tentative X-Ray Disposal Date
1994	Black	2000
1995	Red	2001
1996	Blue (dark)	2002
1997	Green (medium)	2003
1998	Yellow	2004
1999	White	2005

**\*Note:**

Start the color cycle over again, once the white tape is used.

(c) The coding sequence is updated as patients return for additional x-rays. For example, if the patient is x-rayed initially in calendar year (CY) 1994, black tape is attached to the jacket to indicate a tentative disposal date of 1 January 2000. If the patient returns for additional x-rays in CY 1995, the tentative x-ray disposal date is updated by attaching red tape over the black tape.

(9) **Chronological Record of Exposures.** Enter date and type of procedure each time a patient undergoes a radiological study and the film is stored in the film jacket.

(4) **Subfolders (Optional).** Some facilities use lighter weight folders preprinted with the title of a specific type of radiology study (e.g., Bone, MRI (magnetic resonance imaging), Ultrasound, CT (computerized tomography), Nuc. Med. (nuclear medicine)) on each folder. These subfolders are designed to fit inside the master jacket. Where these subfolders are used, enter patient identification information plus the patient's examination history for the particular type of study on the front of the folder using a black permanent marker.

(5) **Automated Systems.** Some MTFs use computer-generated labels to record patient identification and pro-

cedure information. These labels may be affixed to the master jacket or subjackets eliminating the need to repeatedly document the same information by hand. Labels must have a strong adhesive so they do not peel off.

(6) **Copies of the Reports of Radiologic Consultations.** File copies in the file folder promptly on receipt.

(7) Access to and Release of Information. Policy is governed by the Freedom of Information Act and the Privacy Act of 1974. These guidelines are discussed in this section. Radiology films are not routinely considered to be a part of the medical record when release of information from a medical record is requested unless radiology films are specifically requested. Review of original films by professional staff members within the MTF on a need-to-know basis is provided. Provide copies, not originals, when radiology films are released.

(8) **Retirement**

(a) **Chest X-rays of Applicants for Officer Candidate School.** For accepted candidates, forward films to cognizant academy. For rejected candidates, retain films and destroy after 5 years.

(b) **Medical X-rays of Foreign Personnel.** Give x-rays to the individual when they leave the area. Otherwise, destroy after 5 years. Maintain a log of x-rays given to patients, including a notation of patient category.

(c) **X-rays of Members of Other Military Departments.** Give x-rays to the individual when they leave the area, or forward to the service member's primary MTF upon receiving a request for these records. Otherwise, destroy after 5 years. Maintain a log of x-rays given to patients, including a notation of patient category.

(d) **X-rays of Civilian Employees.** Retire positive x-rays of employees separated from Federal employment to NPRC in annual shipments including civilian employees separated from the naval service over 30 days. NPRC will retain the initial chest x-rays, and other positive x-rays for 30 years following separation from Federal employment. NPRC will retain negative x-rays for 5 years following separation from Federal employment then destroy by salvaging.

(e) **Mammograms.** The American College of Radiology, in 1988, resolved that mammograms (positive or negative) should be retained for up to 5 years, or more if required by State or Federal acts, then dispose like other films. When a patient changes primary MTFs, and when requested by the patient or a physician, give the mammograms (or a copy) to the patient to transfer with them. If the patient has already transferred when the request is received, the MTF should mail the mammograms to the next MTF. The original MTF should transfer any studies to the next MTF.

(f) **Other Medical X-ray Films, Echograms, etc.** Retain and dispose following SECNAVINST 5212.5 series.

(9) **Restrictions.** The following restrictions are designed to establish a standard x-ray film jacket for transfer and interfiling between Medical Department activities, and to facilitate cross-servicing between Navy, Army, and Air Force treatment facilities.

(a) No temporary data or notation (such as the patient's home address, telephone number, or sponsor's duty station) shall be written on the front or back of forms NAVMED 6760/0-9. However, this restriction does not preclude the use of labels or tabs identifying the activity maintaining the patient's x-ray file. Such labels, or tabs, can expedite transfer and return of jackets between component activities of medical activities.

(b) Use of Substitute Jackets. No x-ray jackets shall be substituted for the prescribed forms NAVMED 6760/0-9. Use of Army or Air Force forms for terminal digit filing of x-rays is not authorized. Commercially developed x-ray jackets and filing systems shall not be used in lieu of the prescribed standard forms and systems.

(10) **Preparation of the Alphabetic Cross-Reference Locator.** An alphabetic cross-reference locator file shall be maintained as the locating media for x-ray jackets in the terminal digit file. The locator file shall be prepared at the time the record is established. The locator file may be maintained on index cards or on automated data processing (ADP) machine listings. As a minimum, the locator shall include the patient's name and family member prefix code and the sponsor's SSN.

(11) **Chargeout Control.** When x-ray jackets are removed from file, a chargeout form shall be retained in file, in place of the jacket. A standard, general purpose chargeout form, such as Optional Form (OF) 25, Shelf File Chargeout Record (legal size) may be used for this purpose. The following minimum data shall be recorded on each chargeout form.

- (a) Patient's FMP and sponsor's SSN.
- (b) Patient's name.
- (c) Name of practitioner or clinic receiving the record.
- (d) Chargeout date.

The x-ray film room staff will develop a system to account for and recover charged out and delinquent x-rays. X-rays which have been charged out for more than 5 days will be considered delinquent.

**(12) Transfer of X-ray Jackets**

(a) Temporary Transfer. When x-ray jackets are transferred to another MTF for consultation, specialty treatment, or other purpose, a chargeout record shall be prepared as prescribed in article 16-33(11) above. Followup shall be conducted at regular intervals to ensure prompt return of x-ray jackets. OF 25, Shelf File Chargeout Record, is available from General Services Administration supply depots.

(b) Permanent Transfer. When x-ray jackets are transferred permanently to another MTF, a chargeout record shall be prepared as prescribed in article 16-33(11). The chargeout record shall be retained in the file until the disposal date of the transferred x-ray jacket. The chargeout record may be color-coded (taped) to show the disposal date following article 16-33(8).

(13) **Disposal of X-rays.** X-rays shall be disposed of following SECNAVINST 5212.5 series. Normally, x-rays are retained at the MTF until the disposal date. If, however, space is not available to retain x-rays for the full time-frame, prescribed by SECNAVINST 5212.5 series, forms NAVMED 6760/0-9 may be retired to the local Federal records center for interim storage and disposal. The x-ray jackets shall be retired in numerical (TDSSN) order and shall be accompanied by corresponding locator cards (or other cross-reference media) in alphabetical order. Civilian employee x-rays are retired or disposed of following SECNAVINST 5212.5 series to the National Archives, National Personnel Records Center (Civilian), 111 Winnebago Street, St. Louis, MO 63118. X-rays of foreign civilian personnel can be retired to the National Personnel Records Center using the same guides as for civil service employees.

(14) **Ordering Information.** NAVMED 6760/0-9, Medical X-Ray Film Jackets are available through the Navy Supply System and can be ordered per NAVSUP P-2002D, citing following stock numbers:

Form Number	Stock Number	Color
NAVMED 6760/0	0105-LF-008-6200	Orange
NAVMED 6760/1	0105-LF-006-9000	Green
NAVMED 6760/2	0105-LF-006-9100	Yellow
NAVMED 6760/3	0105-LF-007-4200	Grey
NAVMED 6760/4	0105-LF-006-3800	Tan
NAVMED 6760/5	0105-LF-007-0700	Blue
NAVMED 6760/6	0105-LF-007-9100	White
NAVMED 6760/7	0105-LF-007-8300	Brown
NAVMED 6760/8	0105-LF-006-3600	Pink
NAVMED 6760/9	0105-LF-007-4000	Red

(15) **Optional Form 25 (1-75), Charge-Out Record, NSN-7540-00-823-8132,** is available from the Federal Supply System through normal supply procurement procedures.

---

**16-34 Adolescent Clinic  
Records**

---

(1) Many MTFs treat, counsel, and advise adolescents concerning family-life issues. All health care providers

must be fully aware of the State laws concerning these issues.

(2) Use the policies established regarding the issues above to guide documentation and records management. The MRA maintains general management of these records, and the records are subject to QA program review.

## Section VI

# Medico-Legal Issues

Article	Page
16-35 <b>General</b>	16-49
16-36 <b>Applicable Guidelines &amp; Laws Affecting Maintenance and Disclosure</b>	16-50
16-37 <b>Handling of Medical Information</b>	16-51
16-38 <b>Entries By Health Care Professionals (HPs)</b>	16-58
16-39 <b>Corrections to Entries</b>	16-58
16-40 <b>Amendments to Medical Records</b>	16-58
16-41 <b>Removal of Information</b>	16-59

## 16-35

### General

(1) **Purpose.** This section covers the medico-legal, confidentiality, and release of information issues associated with medical records. Medical records contain personal information about the patient which must be safeguarded per the law and the ethical practice of medicine. All personnel who handle records must learn the necessary precautions to avoid compromise of medical information at all times. The main sources of guidance on release of information from patient medical records are governed by the Privacy Act (PA) of 1974 and the Freedom of Information Act (FOIA).

(2) **Scope.** The policies and directives in this section pertain to all Navy Department personnel responsible for handling medical records. Personnel working with medical records must understand the laws, policies, and procedures governing the maintenance, use, and release of medical records or medical documents. Each command must provide the information in this section at in-service training programs for all staff who handle medical records.

(a) Within DON, medical information is used in diagnosis, treatment, and prevention of medical and dental conditions. Medical information is also used for the health of a command, medical research, and other official purposes.

(b) The basic rules on security of medical records are:

(1) No original IRECs may leave the premises.

(2) HPs or other staff members are to work on the records only on the premises of the MTF or DTF.

(3) Personnel not involved in a patient's care or in medical research will not have access to the patient's medical record. Exceptions to this rule are allowed when access is required by law, regulation, or judicial proceedings, when needed for hospital accreditation, quality of care evaluation, or when authorized by the patient.

(c) Medical information is seen by clerical and administrative support personnel (such as secretaries, transcriptionists, and coders) in processing medical records. These individuals have a professional and ethical obligation to keep medical information confidential and private.

(d) Unauthorized disclosure of medical information is grounds for administrative or disciplinary action against the informant.

(e) Refer to article 16-9 and chapter 23 for additional guidance on collection, safeguarding, use, maintenance, access, amendments, and disclosure of information.

(3) **Responsibility.** COs of Navy MTFs or DTFs are the custodians and local system managers for medical records maintained and serviced within their commands. This responsibility is generally delegated to the MRA.

## 16-36

### Applicable Guidelines & Laws Affecting Maintenance and Disclosure

(1) Congress has enacted four laws which affect the information in medical records: the Privacy Act, the FOIA; the Drug Abuse Offense and Treatment Act; and the Comprehensive Alcohol Abuse and the Alcoholism Prevention, Treatment and Rehabilitation Act, with amendments.

(2) Privacy Act of 1974 (Public Law 93-579, 5 U.S.C. 552a). The law pertains to release of information about a patient to themselves or their legal representative (e.g., person holding legal power of attorney), acting on behalf of the patient.

(a) Medical records and other files designated as *systems of records* are subject to the Privacy Act. Process requests for medical records of deceased patients under FOIA; deceased patients have no Privacy Act rights. Protect the Privacy Act rights of other individuals referred to in the medical records and personnel making entries to the record.

(b) DD 2005, Privacy Act Statement-Medical Records. This is not a consent form. It serves as evidence, as prescribed by the Privacy Act, that the patient was informed of the purpose and uses of the information collected and advised of their rights and obligations on supplying the information. The form applies to any related medical or dental documents required to provide health care. File this form in the medical record to eliminate the need for a separate Privacy Act statement for each medical or dental form contained in the medical records. The signature of the patient on DD 2005 is not mandatory. The individual requesting the patient's signature should in no way coerce or imply that a signature is necessary before treatment is given. If a patient refuses to sign, the requesting individual should note such refusal on the DD 2005 and sign it. A copy of the form may be given to the patient.

(3) SECNAVINST 5211.5 series is the Navy's implementing instruction for the Privacy Act. Fees charged

for copies of parts or entire medical records released under the PA are consistent with SECNAVINST 5211.5 series and NAVCOMPT Manual articles 035875 and 035887. A patient will customarily be provided with a copy of their OREC or HREC at their request, if such a release is not found to be potentially detrimental to the patient's mental or physical health. Such a determination should be documented by a credentialed provider in the medical record on the NAVMED 6150/20. MRB personnel must document the date that a complete copy of the OREC or HREC was provided to the patient and place a signed statement of the same on the left side of the folder just above the DD 2005, Privacy Act Statement-HRECs. The patient must pay the appropriate fees for copies of the record, unless the fee is waived per the Privacy Act. Search fees are not charged for information released under the Privacy Act.

(4) FOIA pertains to public access to information maintained by the U.S. Government. Information is made available to the public, unless disclosure is prohibited by FOIA or another law.

(5) SECNAVINST 5720.42 series, Department of the Navy Freedom of Information Act Program, is the Navy's implementing instruction for the FOIA.

(a) Fees charged for copies of medical records or medical records forms released under the FOIA are consistent with SECNAVINST 5720.42 series and the NAVCOMPT Manual.

(b) Charges for copies of records made by contractors will be specified in the contract. Such charges should not exceed that allowed in SECNAVINST 5211.5 and 5720.42 series and the NAVCOMPT Manual (035875 and 035887).

(6) Drug and Alcohol Abuse Acts

(a) Laws establishing policy for release of information on drug and alcohol abuse patients include: Public Law 92-225, Drug Abuse Offense and Treatment Act of 1972 (21 U.S.C. 1175) and PL 91-616, Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970 and the Amendments of 1974 (PL 93-282)(42 U.S.C. 4582). Regulations implementing the above statutes are in 42 CFR, part 2.

(b) Policy established by the public laws:

(1) Personnel must be knowledgeable about these laws as they contain very specific instructions on the confidentiality of information in drug and alcohol abuse records. The drug and alcohol laws take precedence over other directives about access to information.

(2) The patient or their representative must give specific authorization, in writing, before information about drug and alcohol abuse or rehabilitation can be released from medical records, except as follows:

(a) Within the Armed Forces or between the Armed Forces and those components of the DVA furnishing health care to veterans.

(b) To medical personnel in a bona fide emergency.

(c) To qualified persons for scientific research, management, and financial audit or program evaluation.

(d) By an appropriate subpoena or order of a court of competent jurisdiction after application showing good cause.

## 16-37

### Handling of Medical Information

#### (1) Access to Medical Records

(a) Access is restricted to persons with a legal need-to-know about the information contained in the medical records and personnel tasked to establish, maintain, and dispose of medical records. Safeguard medical records against loss, tampering, defacement, or use by unauthorized persons. When medical information is officially requested for use other than patient care, provide only the information needed to satisfy the request.

(b) Original medical records are not released to any person or agency outside the executive branch of the Government, unless subpoenaed, or the patient, or their legal representative, provides a signed release. Copies of the record or pertinent pages are released when the requirements of this article and other applicable guidelines are met. When responding to a court order or subpoena for medical records, provide a certified copy in place of the original medical record, whenever possible. If the original record is surrendered, maintain a complete copy of the surrendered medical record.

(c) Grant access to medical records by command-appointed investigators, the immediate superior in command (ISIC), other authorized medical inspectors, members of base security, or investigators from the NIS after seeing their identification. No record is protected from NIS.

(d) Representatives of JCAHO, civilian peer review program contract employees, and other accrediting and patient care review bodies may also be allowed to review patient records, if appropriately cleared through the CO.

(e) Allow an individual, even if a minor, to review their medical records, unless a credentialed provider determines that access to such records could have an adverse effect on the mental or physical health of the

individual. Restrictions against access to medical records must be documented in the record on the NAVMED 6150/20. When access is restricted:

(1) Send the record to the physician or dentist who provided the treatment and refer the patient to that HP for explanation.

(2) The credentialed provider explains why access by the individual, without proper professional supervision, could be harmful.

(3) The ultimate decision regarding access rests with the patient or the patient's legal representative.

(f) Release of Information on Adopted Infants. Stamp (or boldly print with black permanent marker) the IREC folders of these newborns Release of Information Restricted. Take special care when releasing information from the records of newborns released for adoption. Before the information is released, all references to the child's natural parents must be deleted. Check State and local laws for specific guidance.

(g) When information is released to a third party, further release by the third party is not authorized without the consent of the patient, their legal representative, or the agency responsible for the records.

(h) Federal Personnel Manual 293-30 contains a sample of form SF 293, detailing the procedures necessary for former or current civil service employees to obtain a copy of the EMF. These forms should be available at all MTFs serving civilian employees. The address for civilian employee record archives is: National Archives, National Personnel Records Center, 111 Winnebago Street, St. Louis, MO 63118.

(2) **Release of Medical Information to the Public** Including the News Media. Refer all calls from the media to the public affairs officer appointed by the CO per the NAVMEDCOMINST 5728.1 series. The following guidance is applicable when there is no public affairs function at the local command:

(a) Only information which does not constitute an unwarranted invasion of patient privacy covered by the Privacy Act is made available to the public. Release of information must not be in violation of the Privacy Act, FOIA, Alcohol or Drug Abuse Acts, accepted medical practice, or existing directives.

(b) DoD guidelines have been developed to maintain a balance between the rights of requestors under the FOIA and the rights of individuals under the Privacy Act. As a courtesy, it is always advisable to request a patient's permission before releasing information (see article 16-37(5)(a)). If the patient is unable to give permission, the next of kin should be notified (if possible) before releasing information to the news media or public.

(3) **The following information may be released** without the patient's consent: name; grade or rate of individ-



ual; date of admission or disposition; age; sex; component, base, station, or organization; and general condition.

(4) **If requested**, the following information may be released without consent: marital status (this is *married* or *unmarried*); occupation or job title; and present medical assessment of condition in the following terms: *stable, good, fair, serious, or critical*.

(5) **The following information** cannot be released without the patient's informed consent: diagnosis or description of disease or injury (such as a burn, fracture, gunshot wound, pneumonia, or chest pain); general factual circumstances, such as suffered a fracture in an automobile accident; or the general area of the body suffering injury, such as burns of the left leg. Do not specify location or description of disease, injury or body part which may prove embarrassing to the individual.

(a) Do not presume consent. A patient who is conscious and competent must be given an opportunity to object to the release of any of the information listed in article 16-37(5). If a patient is not conscious, or not mentally competent, information as in article 16-37(5) may not be released until the patient's condition has sufficiently improved for him or her to object or consent to release of information. When a patient is incompetent, the guardian may make the decision.

(b) Never release, for a routine inquiry, prognosis or sensitive information about the admission of the patient such as sexual assault, criminal actions, drug or alcohol abuse, psychiatric or social conditions, or venereal or other sexually transmitted diseases. In these cases, a statement such as the following can be made: Further details about (individual's name) admission to the hospital are not releasable at this time.

(c) More specific medical information may be provided by the physician if the patient or guardian does not object.

(d) For assistance on the release of information, consult the staff judge advocate or the public affairs office.

(6) **Release to Federal or State Courts or Administrative Bodies.** Refer requests for release of medical information needed for pending litigation to the local staff judge advocate for advice or action. SECNAVINST 5820.8 series governs release of all Government records during the course of litigation.

(7) **Release to Other Government Departments and Agencies**

(a) Release medical information, on request, to other departments and agencies, both Federal and State, which have a legitimate need for the information. Examples are the DVA or Office of Workers Compensation Programs to process a claim in which the person's medical history is relevant. Federal and State hospitals and prisons which

require the information for further medical treatment of a person in their custody.

(b) Do not release information in violation of existing laws.

(8) **Release for Medical Research or Study by Scientific Organizations.** Medical information is released on request of medical research or scientific organizations or other qualified researchers when, in the opinion of the releasing authority, its release is legal and in the public interest. This includes release of information to present or former members of the Armed Forces who need information for private study or research to advance their professional standing.

(a) Qualified persons may have access to Navy medical records in an MTF, record center, MTF of the General Services Administration, or DVA facilities.

(b) Original records must not be removed from the MTF. Furnish space and facilities for review and arrangements for record copies. The exception to this policy is the Armed Forces Institute of Pathology (AFIP). Original records may be released to AFIP per article 23-78. Any other exception must be approved by BUMED (MED-02).

(c) COs of medical facilities cannot borrow retired records for researchers.

(d) Approval of Requests

(1) BUMED (MED-02) will approve requests for research. AFIP is an exception to this rule as is 16-37(8)(d)(2) below.

(2) COs of Navy MTFs have approval authority for requests from personnel under their command whose research projects involve medical records at that MTF. They may grant access only to the records in their own MTF.

(e) Submission of Requests. Excluding the exceptions falling under 16-37(5)(d) above, address all requests from outside and within DON through local channels to Chief, Bureau of Medicine and Surgery (MED-02), 2300 E Street, NW, Washington, DC 20372-5300. Include the following information:

(1) Name and address of the researcher and of any assistants.

(2) Professional qualifications of the researcher and of any assistants.

(3) Description of the researcher's project or field of study.

(4) Reason for requesting the use of Navy records.

(5) Specific records needed and their location.

(6) State inclusive dates when access is needed.

(7) Each person named in the request must sign an agreement listing these conditions:

(a) Information taken from Navy medical records must be treated following the ethics of the medical profession.

(b) The identities of people mentioned in the records must not be divulged without their permission. Photographs of a person or of any exterior portion of their body must not be released without their consent. Any published reports resulting from the study must not identify the individuals whose HRECs were examined.

(c) The researcher understands that permission to study the records does not imply approval of the project or field of study by the Navy Surgeon General.

(d) All identifying entries about a patient must be deleted from abstracts or reproduced copies of the records and the information held in confidence.

(e) Any published material or lectures on the project or study must contain the following statement: *The use of Navy medical records in the preparation of this material is acknowledged, but is not to be construed as implying official DON approval of the conclusions presented.*

(f) Access Authorization Proof. Any approval letter from BUMED allowing access to the records should be shown to the proper authority (head of the PAD or MRA) when requesting access to the records at the MTF level.

**(9) MTF Release of Duplicated Medical Information**

(a) Do not release the information if reproducing it is a burden, unless required by law or instruction or if its release is contrary to existing laws or instructions.

(b) Ensure that names and SSNs of persons documented in the record are deleted.

**(10) Procedures for Loan or Release of Medical Records**

(a) Review the request for release of medical records information for completeness, required signatures, authorization, Surgeon General approval for research, or subpoena, as appropriate, based on guidance provided above.

(b) Review the records to decide if the information requested is present and if there is sensitive information in the record.

**(11) Medical Record Chargeout System**

(a) Each MTF must have procedures to control access and flow of medical records. These procedures include both the charging out of records and followup to ensure that the record is returned within a designated length of time. The most common chargeout systems involve the use of a NAVMED 6150/7, HREC receipt, or a 3x5 inch card or form used with file chargeout guides. Record the following minimum data on each chargeout card or form:

- (1) FMP code and SSN.
- (2) Member's name (last, first, middle initial).
- (3) Name of practitioner or clinic receiving the record.
- (4) Chargeout date.

(b) Keep the completed chargeout form in the file until the record is returned. A color coding system may be used with the chargeout form or card to denote the day or week the record is charged out from the file. Use of bar codes for record tracking can also be effective.

(c) Advance Chargeouts for Appointments. Each MTF or clinic command must develop a system for advance chargeout and delivery (by command staff) of medical records maintained at the command for scheduled clinic appointments. Command staff must return medical records to the MRB after each patient's last appointment for the day unless the patient is scheduled to return to the clinic the next day. MRB personnel should conduct a trend analysis of medical records not returned per the above guidelines and report repeated violators to the medical records committee. Direct requests for exceptions to this policy to the local medical records committee.

(1) Do not charge out records longer than necessary. Records sent to in-house clinics must be returned the same day as the clinic visit.

(2) Return other medical records charged out from the file as soon as possible, but not more than 5 working days from the chargeout date. Develop local policies and procedures for the recovery of medical records charged out over 5 working days.

(3) Submit a *change-of-charge* to the MRB when a charged-out record is moved to a location other than the clinic, office, or department to which it was signed out. Place reports that arrive while the record is charged out in the temporary folder or outguide until the record is returned.

**(12) Safeguarding Medical Information in Automatic Data Processing (ADP) Systems.** ADP systems can subject personal information to special hazards, compromise, alteration, dissemination, or use, unless adequate precautions are taken. Protect medical information during processing and restrict access to information in ADP systems. Refer to BUMEDINST 5239.1 series, Bureau of Medicine and Surgery (BUMED) Automatic Information System (AIS) Security Program for specific instructions.

**(13) Record Requests.** (*Release of information from secondary records is discussed in article 16-37(15).*) To request records or medical information from another MTF, medical facilities must use DD 877, Request for Medical/Dental Records or Information. Procedures for handling requests are as follows:

**(a) The requesting MTF must:**

- (1) Follow the instructions preprinted on the form for the requesting activity.
- (2) Send the original and first copy to the source of the record or information.
- (3) Retain the second as the file copy.

(b) **The custodian of records** receiving the DD 877 must handle the request as follows:

(1) If the requested records are available, the custodian will:

(a) Complete items 8b and 11 through 14 of DD 877. Check the appropriate boxes in item 8b to indicate whether military records, DVA records, or both are being sent.

(b) Place the first copy of the DD 877 in a terminal digit folder and file to replace the forwarded record. If several records are taken from several file locations, place a chargeout card or a copy of the DD 877 at each location. If a card is used, record the following statement: (type of records) on (FMP, SSN, and name of patient) were forwarded to (address) on (date) in response to DD 877 received from (address). These records cover treatment during (inclusive dates).

(c) Send the original DD 877 and the requested records to the address shown in item 1(9).

(d) When the records are returned and filed, destroy the copy of DD 877 in the file and remove the out-guides.

(2) If the requested record has been sent to a records center or another MTF, forward the original and the copy of DD 877 with a transmittal letter to the MTF currently holding the record.

(3) Requests for Medical Records of Navy Beneficiaries Retired to Storage

(a) For recently deceased (within the first 4 months) active duty member, send a written request to Commander, Naval Military Personnel Command (NMPC-663), Arlington Navy Annex, Room 1708, Washington, DC 20370-5100.

(b) Inactive Reservists. Telephone NRPC to verify that the HREC is on file. Dial the appropriate NRPC telephone number according to the last two digits of the sponsor's SSN as follows:

Last Two Digits Sponsor's SSN	DSN Prefix	Commercial Area Code and Prefix	Last Four Digits Telephone Number
00-24	8-363	(504) 948	-5400
25-49	8-363	(504) 948	-5404
50-74	8-363	(504) 948	-5430
75-99	8-363	(504) 948	-5434

Followup with a written request to Naval Reserve Personnel Center, 4400 Dauphine Street, New Orleans, LA 70149.

(c) HRECs Retired to Storage

(1) If the member separated, or deceased prior to January 31, 1994, send a written request to National Personnel Records Center, Military Personnel Records, 9700 Page Boulevard, St. Louis, MO 63132-5100.

(2) If the member retired or separated after January 31, 1994, send a written request to the Department of Veterans Affairs, Service Medical Records Center, P.O. Box 150950, St. Louis, MO 63115-8950 for the following categories of personnel:

(a) USN/USNR members released from active duty, after serving on active duty over 29 consecutive days (including 1 year recall, active duty for special work, and active duty for training).

(b) USN/USNR members discharged from the naval service (including members of the Selected, Ready, and Standby Reserve).

(c) USN/USNR retired members (including transfer to the fleet and retired Reserve, permanent disability retired list (PDRL), and temporary disability retired list (TDRL)).

(3) Send a written request to the Naval Reserve Personnel Center, 4400 Dauphine Street, New Orleans, LA 70149-7800, to obtain copies of HRECs for the following categories of individuals:

(a) Members of the Standby Reserve.

(b) Members of the Individual Ready Reserve (IRR).

(c) USNR personnel transferred from inactive duty training status to the IRR or Standby Reserve.

(d) Volunteer training unit (VTU) members transferred to the IRR or Standby Reserve.

(4) Send a written request to the Marine Corps Reserve Center, 10950 El Monte, Overland Park, KS 66211-1408 to obtain copies of HRECs for members of the Marine Corps Standby Reserve, IRR, USMCR personnel transferred from inactive status, and VTU members who transferred to the IRR or Standby Reserves.

(5) HRECs for Navy personnel who have been declared deserters are maintained, along with the service record and dental record, by the Bureau of Naval Personnel, Washington, DC.

**(c) Procedure for processing requests for retired medical records**

(1) Review request to determine whether the records have been retired. If the record has been forwarded for retiring then the activity holding the record should respond to the inquiry.

(2) Requests for retired records should be checked for completeness, including signature of the individual. The chart below shows the information required by NPRC, DVA, USMC, and BUPERS to locate specific records within their files. If pertinent information is omitted, return the request to the sender. Inform the requestor of the information required and direct the completed request be sent to NPRC.

(3) Include the following information when requesting medical records from NPRC:

- (a) Full Name, (at time of treatment)
- (b) Status (specify whether active duty, retired, dependent, other)
- (c) Grade/Rate (military only)
- (d) Social Security Number (sponsor's)
- (e) Service Number (Sponsors: if applicable)
- (f) Branch of Service
- (g) Inclusive Dates of Active Military Service
- (h) Date Admitted to Treatment MTF
- (i) Date of Last Treatment
- (j) Reason For Treatment.

(d) **Forward requests to NPRC** for copies of retired record which are complete. If the activity receiving the request also retired the record, then write NPRC's location and accession number on the command's copy of the Records Transmittal and Receipt form, SF 135. This information should be annotated on the request to assist NPRC in locating the correct record. The requestor should be notified of this referral.

(e) **The notification of referral** should clearly state that NPRC will answer the inquiry. NPRC and DVA handles all requests as routine, even if another office or agency requires the information to answer a congressional inquiry.

(f) **If the congressional is referred to both NPRC and DVA for action**, then NPRC has the responsibility to respond.

(g) **If the record was never maintained** in the MTF file, complete the appropriate block in item 12 and return the form to the requestor.

(14) **Release of Copies of Medical Records to Insurance Companies, Other Third Party Payers, Civilian Health Care Providers, and Lawyers.** Release of copies of medical records or abstracts of medical records to these individuals is done per the FOIA. If the individual is a legally-appointed representative of the patient, release information per the Privacy Act.

(15) **Release of Information from Secondary Records.** All information released from secondary records is done through the MRB, in coordination with the cognizant clinic or department.

(a) An MRA may release, on a need-to-know basis, a copy of a secondary record in response to a written request ensuring that Navy procedures for the release of personal information are followed. Copies of requested information may be mailed directly to an authorized requestor by certified mail.

(b) Secondary records may be charged out from file to an MTF or DTF health care provider with a need for the record. Written requests from Medical Department personnel within the MTF or BUMED are not required.

(c) NIS agents and any other investigative service agents with adequate identification may also have access to secondary records.

(d) Secondary records may be transferred to another MTF or BUMED by certified mail from the holding MTF MRA to the requesting MTF or BUMED code MRA. Patients are not routinely authorized to handcarry secondary records.

#### (16) Disclosure Accounting

(a) Keep an accurate account of the date, nature, and purpose of each disclosure, and name and address of the person or agency to whom disclosure is made.

(1) The only exceptions to this requirement are for disclosures made to personnel in DoD who have a need for the record in the performance of their duties and for disclosures made under the FOIA.

(2) An accounting is required for disclosure outside of DoD even with the written consent or at the request of the individual concerned.

(b) Use OPNAV 5211/9, Record of Disclosure-Privacy Act of 1974 to record each disclosure and include the form in each patient's medical record from which disclosure is made.

(1) When disclosure is made by mail, include a copy of the MTF's or DTF's forwarding transmittal form or letter in the patient's medical record.

(2) When the disclosure is made by personal review, keep a copy of the request or authorization to review the record, a signed and dated statement that the review was completed, and a listing or description of any copies made of the record.

(c) Disclosure accounting makes it possible for patients to learn to whom their records have been disclosed, provides a basis for advising recipients of records of disputed or corrected entries, and provides an audit trail for subsequent review of activity compliance.

#### (17) Transfer or Distribution of Medical Records

(a) **Temporary Transfers.** When a treatment record is transferred temporarily to another activity (e.g., for consultation or specialty treatment), follow the procedures above to prepare and maintain chargeout cards or guides.

(1) Patients frequently handcarry their medical records when they have an appointment external to the record keeping MTF. If resources and time permit, however, the record should be delivered to the consulting provider with instructions to return it the same way. Do not jeopardize patient care or unnecessarily inconvenience the patient.

(2) If the treatment record is handcarried by the sponsor (active duty or retired), spouse, or an adult dependent, release of the records to the sponsor or adult dependent must comply with the instructions on NAVMED

6150/8, Outpatient Transfer Release Request and Transfer Receipt. ORECs of adult dependents may be released to the sponsor or spouse if authorization is provided for each record to be released. Medical records of minor children may be released to the parent, sponsor, spouse, other adult dependent family member, or the child's legal guardian. In divorce cases, release dependent records only to the parent who has been awarded custody of children by a court order.

(3) **Excerpts From Records.** When determined by the treating HP to be essential for patient care, give excerpts (copies) of relevant portions of ORECs to patients for temporary absences, such as vacations. Release excerpts to the sponsor or adult dependent as described above. If the patient receives medical care during the temporary absence, file the original records of treatment in the Navy record.

(b) **Permanent Transfers to Ships or Stations.**

(1) Upon notification a member is to be transferred, pull the HREC from file. Determine whether there are any secondary records. Refer to article 16-7.

(2) If there is no primary record, establish a new record folder for the member per article 16-13 and 16-23 and insert an SF 600 on the right side of the folder. Make the following entry on the SF 600: (Insert date) HREC folder opened on this date. No other HRECs available at (insert MTF name and address).

(3) Verify the HREC following article 16-23(6) and certify that the member has been processed for transfer. Include the dental record before transfer if it was not maintained with the HREC.

(4) Complete medical record chargeout following article 16-37(11). Complete transfer secondary records following article 16-37(17).

(5) Officers and enlisted members ordered to active duty or transferred to another ship or station will be allowed to handcarry their primary HREC. If the command determines that it is not in the best interest of the member or the Navy to have the HREC handcarried, forward the HREC via certified mail or in the custody of authorized unit personnel.

(6) **Foreign Service Expeditions.** When a member is to participate in a foreign service expedition and there is a possibility of loss or seizure of the record, it may be advisable to make copies of pertinent parts of the HREC and the dental record and retain in a safe place. This documentation should include the NAVMED 6150/20, SF 601, NAVMED 6000/2 and current SF 600s. A copy of the SF 603 and 603A should be included from the dental record. This provides identification media should there be a fatality and the original record is lost or destroyed. The copies should be placed in a health or dental record jacket and

be clearly marked as a DUPLICATE RECORD. See article 16-19.

(7) **Independent Duty.** If a member is ordered to independent duty where there is no medical department representative, keep the HREC with the member's service record.

(8) When practicable, have the HREC accompany each member transported by the Military Sealift Command.

(9) In instances of unauthorized absence before departure of a ship or other unit on an extended assignment, deliver the HREC to the CO to accompany the member's service record.

(10) When a patient is received aboard ship for transporting, the medical officer or the medical department representative must maintain the HREC. The record of the chain of events must remain unbroken. Record any care provided or changes of diagnosis in the prescribed manner.

(c) **Dependent Transfers.** When a sponsor changes stations, the dependent (in the case of a minor or incompetent adult) transferred with their sponsor to another permanent duty station, the sponsor will generally be allowed to handcarry the OREC to the next primary MTF. ORECs of adult dependents can only be released to the patient to whom the record pertains, unless that patient signs a note allowing another individual to obtain their records. If the command determines that handcarrying is not in the best interest of the patient or the Navy, forward the OREC via certified mail. See article 16-37(17)(a).

(d) **Transfer by Aeromedical Evacuation.** A copy of the IREC and the original OREC or HREC must accompany patients transferred by aeromedical evacuation.

(e) **Hospitalization at Naval MTFs**

(1) When a patient is transferred to a naval MTF, include the HREC or OREC and a copy of the IREC with the patient.

(2) If an active duty member or their dependent is admitted directly to a naval MTF, while away from the member's present duty station or primary treatment MTF, forward the HREC or OREC to the admitting MTF upon request.

(3) When treatment is completed, and the patient maintains the record at another MTF, sign the record out to the patient for return to the originating MTF's custody. If a patient departs without the OREC, the MRA should forward the record to the appropriate MTF. The MTF MRA must ensure records, reports, or any other part of a medical record is delivered to the patient or to the appropriate custodian of the record. BUMED does not store records or act as the repository for lost records. Do not send medical or personnel records or loose sheets from medical or personnel records to BUMED. See article 16-21.

(4) When a member is directed to proceed home and await final action of the recommended findings of a physical evaluation board, make an entry to that effect in the HREC.

(5) The HREC or OREC must reflect the care and treatment rendered during an inpatient stay. Accomplish this by placing a copy of the narrative summary (SF 502), the short form admission (SF 539), operation report (SF 516), and medical board report, if appropriate, in the record. When this cannot be done due to a delay in the processing of the report for signature, make a note on an SF 600 as an interim measure. Include in the note: the reason for admission; the tests, treatments, and procedures performed; the current condition; medications; and instructions. Never unnecessarily delay a patient's discharge from the hospital after treatment is completed for administrative reasons.

**(f) Active Duty Member Hospitalization and Transfer to Federal Facilities other than Navy:**

(1) Upon transfer of a Navy or Marine Corps active duty or dependent patient to a Federal MTF where a naval medical unit or Navy liaison personnel are attached, have the HREC or OREC accompany the patient, or send as soon as possible.

(2) Upon transfer of a Navy or Marine Corps active duty or dependent patient to a Federal MTF where no naval medical unit or Navy liaison personnel are attached, apply the following:

(a) Army or Air Force Facilities. Have the patient bring the HREC or OREC and a copy of the IREC or send as soon as possible. For direct cross-servicing, see article 16-13(10). Request the MTF to return the HREC or OREC to the member's duty station or the custodian of the dependent's primary record, as appropriate, upon disposition of the patient.

(b) Veterans Administration Medical Centers (VAMCs). Forward copies of the HREC and IREC of a patient transferred to a VAMC, to the appropriate authority, per NAVMEDCOMINST 6320.12 series. Transfer the original HREC to the cognizant MTF. If the member appeared before a physical evaluation board, send the original medical board report for filing in the HREC. Upon completion of treatment or separation from the naval service, the VAMC will send a copy of the narrative summary for placement in the HREC. The cognizant MTF or the Office of Medical/Dental Affairs forwards the HREC to the cognizant personnel activity.

(1) If a Navy or Marine Corps member is hospitalized in a civilian medical facility and is to be moved to a VAMC, a copy of the IREC should accompany the patient. Charges for copies of IRECs will be paid by the naval MTF having cognizance over the patient or the Office of Medical/Dental Affairs.

(2) A Navy or Marine Corps command requiring medical records or x-rays held by the DVA on current or former members of the naval service should request such records directly from the cognizant DVA activity using DD 877. These records are official military records on loan to the DVA or records of treatment provided to members or former members at DVA facilities. When a Navy MTF holds records received from a VAMC, return original DVA records or x-rays to the DVA activity when they have served their purpose. Do not return official military HRECs. Send a copy of the HRECs if the DVA requests return of the information.

(3) Emergency Hospitalization and Direct Admission to a VAMC. Forward a copy of the HREC, if requested. On the return of an active duty member to duty, place a copy of the narrative summary and operation report in the HREC maintained at the custodial activity. If not forwarded by the DVA, the custodial activity should request an SF 502, Clinical Record-Narrative Summary and SF 516, Medical Record-Operation Report for filing in the HREC.

**(g) Hospitalization at Civilian Medical Facilities**

(1) When an active duty member is admitted to a civilian medical facility, forward the HREC or OREC to the activity having administrative cognizance, after confirming that the member's length of stay warrants the transfer. The activity having administrative cognizance will continue to maintain the HREC until disposition is completed. Place a copy of the narrative summary and operation report in the HREC on the member's return to duty.

(2) When a dependent is admitted to a civilian medical facility for treatment involving brief periods of hospitalization, retain the OREC at the activity having custody.

(3) Forward a copy of pertinent medical information needed by the civilian treating facility from the OREC or HREC.

**(h) Admission to a Hospital in a Foreign Nation**

(1) When a member is hospitalized at a foreign medical facility, make an entry of that fact in the HREC. Send the HREC to the MTF having administrative cognizance. This activity will continue maintenance until disposition is completed. On return to duty, place an English translation of the narrative summary in the HREC.

(2) When a dependent is hospitalized at a foreign medical facility, make an entry to that fact in the OREC. Place an English translation of the narrative summary in the OREC.

**(i) Disposition of Records of Foreign Military Personnel and Their Dependents.** Dispose of these IRECs along with other IRECs and ORECs in file. At time of retirement or sponsor transfer, whichever is first, the MTF may keep copies of pertinent sections of HRECs and ORECs and give the original dependent's records to the sponsor

for minor dependents. Records of adult dependents will be given to the applicable dependent. Allow foreign military personnel to handcarry their HRECs to their next duty station when permanently transferred.

## 16-38

### Entries By Health Care Professionals (HPs)

(1) **Adverse Entries.** U.S. Navy Regulations, articles 1123 and 1124 require that naval personnel be advised in writing when entries are made in their medical records relative to disease or injury attributed to misconduct, or indicating the use of intoxicants or habit-forming drugs to a degree presumed to disqualify the member physically, mentally, or morally for performance of duties.

(a) The record custodian must ensure that notification is made in writing to the individual concerned and to the individual's CO. If a Privacy Act request is received for a record containing an adverse entry for which the member has not received notification, the request must be processed under the provisions of the Privacy Act.

(b) To assure that a member is afforded an opportunity to submit a statement of rebuttal, U.S. Navy Regulations require HPs to allow the member to see related medical records, unless not medically advisable. HPs are not to render opinions of line of duty misconduct, as this is the parent command's responsibility.

(c) Whenever an HP considers it inadvisable for the member concerned to be informed of or see an adverse entry in the record, the HP must inform the CO and make a note to this effect in the record. Later, if the patient's condition permits, the cognizant HP will arrange for the patient's access to the record and permit the patient to submit a statement in rebuttal. Make an entry that a review was made by the member. The cognizant HP will notify the MRA of an adverse entry. The MRA will assist the HP in ensuring the member's acknowledgement of the entry and that the member is offered an opportunity to make a statement in rebuttal. Always seek legal advice regarding the above matters.

(d) To ensure that notification of an adverse entry is made in writing to the individual concerned, require the individual to record and sign the following entry on the SF-600:

I understand my rights under article 1123, U.S. Navy Regulations (1990) to submit a statement.

## 16-39

### Corrections to Entries

(1) Corrections to entries may be made by personnel authorized to document in the medical record, preferably by the person who made the original entry. To correct an entry, draw a single line through the information that is in error. The information must remain readable, since deletion, obliteration, or destruction of medical record information is not authorized except through proper channels as outlined in articles 16-39, 16-40, and 16-41. Add the new information, date, and sign with full identification per section III. If helpful, an explanation of why the corrected entry was made may be written.

## 16-40

### Amendments to Medical Records

(1) References: The Privacy Act (PA) of 1974, SECNAVINST 5211.5 series, MANMED articles 23-70 and 23-73.

(2) Individual Review and Amendment: Encourage individuals to periodically review the information maintained about themselves in the medical or dental records, and to avail themselves of the amendment procedures established by this manual.

(3) Information on the right to amend, form of request for amendment, content of the amendment request, and appeals of denial, is available in the SECNAVINST 5212.5 series, BUMEDINST 5210.9 series, and SECNAVINST 5211.5 series.

---

**16-41**

**Removal of Information**

(1) All Federal agencies are required to maintain only information about an individual that is accurate, relevant, timely, complete, and necessary to accomplish the purpose of that activity.

(2) Original medical information about a patient should not be removed from a medical record, without proper authorization, even if it is not recorded on an approved form. Filing of unauthorized forms in the medical record, however, is strongly discouraged.

(3) Expungement is available through the local system manager, the naval activity head, BUMED, OJAG General Counsel (for the SECNAV), the Board for Correction of Naval Records, or the Federal Court System.

(4) The procedures for a person to remove an adverse entry from their medical records is contained in the Privacy Act of 1974.



## **Section VII**

# **Instructions For Completing Selected Forms**

<b>Article</b>	<b>Page</b>
16-42	16-62
16-43	16-62
16-44	16-62
16-45	16-63
16-46	16-63
16-47	16-64
16-48	16-64
16-49	16-64
16-50	16-66
16-51	16-66
16-52	16-66
16-53	16-67
16-54	16-67
16-55	16-67
16-56	16-68
16-57	16-68
16-58	16-69
16-59	16-71
16-60	16-71

16-61	<b>NAVMED 6150/2, Special Duty Medical Abstract</b>	<b>16-72</b>
16-62	<b>NAVMED 6150/4, Abstract of Service and Medical History</b>	<b>16-72</b>
16-63	<b>NAVMED 6150/20, Summary of Care</b>	<b>16-72</b>
16-64	<b>NAVMED 6300/5, Inpatient Admission/Disposition Record</b>	<b>16-74</b>
16-65	<b>DD 602, Patient's Evacuation Tag</b>	<b>16-74</b>
16-66	<b>DD 771, Eyewear Prescription</b>	<b>16-75</b>
16-67	<b>Fetal Monitoring Strips</b>	<b>16-75</b>
16-68	<b>Record of Ambulance Care</b>	<b>16-76</b>
16-69	<b>Deoxyribonucleic Acid (DNA) Sample Medical Record Pouch</b>	<b>16-76</b>

**16-42 Introduction**

(1) Provides general requirements on the description, purpose, and completion of selected forms. Personnel at each MTF must provide more specific guidance about the uses of these and other forms through their medical records committee or QA program.

**16-43 SF 88 Report of Medical Examination**

- (1) Prepare an SF 88, Report of Medical Examination, whenever a complete report of physical examination is required.
- (2) Do not pretype, preprint, or otherwise enter or reproduce in advance entries in block 17 on the SF 88.
- (3) If a typographical or clerical error is made, i.e., transposition of numbers or letters, the person making the correction must draw a single line through the erroneous entry, initial above the error, and make the corrected entry in the same block. If space is not available make the corrected entry in block 42 and identify the erroneous and corrected entry by number.

**16-44 SF 93 Report of Medical History**

(1) The purpose of the SF 93, Report of Medical History, is to provide a complete personal medical history and a source of information supplemental to that reported on the SF 88. The SF 93 provides a current, concise, and comprehensive record of an examinee's personal medical history before entrance into the naval service and any subsequent change in status.

- (2) Preparation
  - (a) Complete the personal information items of 1 through 7, per instructions that apply to corresponding items of the SF 88. This information may be handwritten, or typed.
  - (b) Item 8 will contain a handwritten statement from the examinee regarding present state of health and any medications being taken.
  - (c) Items 9 through 24 must be individually checked. Afford every assistance to the examinee to assure full and clear comprehension of the terminology appearing in items 9 through 24, enabling the examinee to provide a concise and accurate history. The SF 93 is information of significant or chronic disorders vice one-time events of minor illness or disorders.
  - (d) Item 25 will be prepared and signed by the medical examiner per article 15-8. The examiner reviews data supplied in items 9 through 24 and uses item 25 to number, comment, and elaborate on all "yes" answers given. The examiner indicates conditions considered disqualifying as "CD" or not considered disqualifying as "NCD". The number of pages attached to the original SF 93 should be

indicated in the space provided on the lower right back of the original SF 93. Document complete provider identification. See article 16-15(7).

(e) On all subsequent medical examinations that require an SF 88, complete the SF 93 providing the specifics of an interval medical history covering the period since the last SF 93 was completed.

**16-45**

**SF 502  
Medical Record  
Narrative  
Summary  
(Clinical Record)**

(1) General. This is a summation of a patient's hospitalization in narrative form. It is used to provide a brief, accurate account of the care and treatment given. The narrative summary must include all procedures and diagnoses. These must agree with those listed on the Inpatient Admission/Disposition Record (NAVMED 6300/5) and on the operation report (if applicable).

(2) Include the following information on each narrative summary:

(a) The reason for hospitalization, including a brief clinical statement of the chief complaint and history of the present illness.

(b) All significant findings.

(c) All procedures performed and treatment given including patient's response, complications, and consultations. Identify any prosthetic device permanently implanted in the body (i.e., nomenclature of prosthesis, manufacturer, and serial numbers if provided). Designate primary procedure.

(d) The condition of the patient at transfer or discharge.

(e) Discharge instructions given to the patient or their family (i.e., physical activity permitted, medication, diet, and followup care).

(f) All relevant diagnoses (including complications) by the time of discharge or transfer. Designate primary diagnosis.

(g) List of principal providers or attending physicians.

(h) Signature or countersignatures of attending physicians.

(3) A complete, signed copy of the Narrative Summary (SF 502) or Abbreviated Medical Record (SF 539) must accompany a patient who is transferred to another medical facility.

(4) If possible, discharge each active duty patient with a copy of the narrative summary, which must be taken to the parent command for information and inclusion in the HREC. Disposition instructions stating any limitations, medications, and followup care must be well documented so that superiors are aware of limitations. An active duty member may not be detained solely for administrative reasons.

(5) A complete, signed copy of the Narrative Summary (SF 502), a copy of the Abbreviated Medical Record (SF 539), or (inpatient) medical board report, as appropriate, must ultimately be included in the OREC or HREC. Forward a copy of the final typed and signed SF 502 to the activity holding the record for inclusion in the OREC or HREC. This requirement does not have to be fulfilled concurrently with the actual inpatient disposition process.

(6) If the active duty member's disposition from inpatient status is to other than full duty, provide documentation at the time of discharge on the member's physical limitations, diagnosis, prescribed medications, requirements for outpatient followup appointments, and other limitations. Although provision of this information is imperative to both the patient and the receiving command, it does not need to be provided initially on an SF 502, SF 539, or a medical board report. Include the information when these reports are prepared.

(7) An interim report on inpatient disposition should accompany all active duty patients discharged from the MTF when the SF 502, SF 539, or medical board report is not ready at the time of disposition. Where the interim reporting system is in effect, a locally developed Interim Report of Inpatient Disposition may be inserted into the patient's HREC or OREC while awaiting completion of the needed reports.

(8) Automated systems may use plain white paper to produce a narrative summary or medical board report, however, the title must be clearly displayed. See article 16-15(4).

**16-46**

**SF 503  
Clinical Record-  
Autopsy Protocol**

(1) This form is used for the provisional anatomic diagnosis and completed autopsy protocol. Attach a copy of the protocol and file with this form. The pathologist's provisional anatomic diagnoses must be entered in the IREC within 72 hours following the autopsy; and the complete

protocol is to be entered within 60 days. A complete protocol on SF 503 includes information shown below:

- (a) Gross anatomical findings.
- (b) Provisional pathologic diagnoses.
- (c) Final diagnoses based on definitive microscopic findings. Indicate clearly on the form whether the findings reported are provisional or final. In some cases, there will be no cause of death determined.

**16-47**

**SF 504, Clinical Record-History Part I; SF 505, Clinical Record-History Part II; and SF 506, Clinical Record-Physical Examination**

(1) Prepare and sign an admission workup on SF 504, SF 505, and SF 506 within 24 hours after admission. Ensure that it is as pertinent and complete as needed for proper patient management. Before surgery is performed under general anesthesia, the IREC must include a complete history and a current, thorough physical examination. Cardiopulmonary system findings must be recorded fully; do not use terms such as *normal*, *WNL*, and *negative*. These reports are not needed in emergencies. For emergency surgery, the physician need only report vital signs, pertinent physical findings, and any allergies (if known).

(2) If an adequate history and physical examination report arrives with patients transferred from other medical facilities, an interval progress note stating no change will suffice. Report significant changes. If the patient arrives without a history and physical or with inadequate information, one must be done. If the inadequacy was caused by negligence, the QA department advises the transferring MTF.

(3) Readmission. When a patient is readmitted within 30 days for the same or a related condition, an interval history and physical may be written in the progress notes in place of a complete history and physical examination. Describe any pertinent changes in these reports. Interval reports are allowed only if the IREC with the original history and physical are sent to the attending physician's attention and are available for review.

(4) Only staff physicians or privileged staff record admission history and physical examinations on SF 504, SF 505, and SF 506.

**16-48**

**SF 508 Doctor's Orders**

(1) A patient shall not be admitted or given medication, special diet, or treatment except upon the orders of a physician, dentist, or other authorized HP. All orders for diagnostic procedures, treatments, medications, transfer, or disposition shall be recorded legibly in black ink or type-written, dated and signed by the HP. Routine orders may be preprinted, completed and signed by the responsible HP. Distinction should be made between verbal and telephonic orders. Telephone orders will be taken only by registered or licensed nurses and countersigned by the physician not later than 24 hours after the order is given. Verbal orders must be countersigned at the time they are recorded. Appropriate orders will be recorded by the HP primarily responsible for the patient when resuscitative services are to be withheld or life-sustaining treatment is to be withdrawn.

**16-49**

**SF 509 Medical Records-Progress Notes**

(1) Describes chronologically the clinical course of the inpatient in the progress notes. These notes should reflect any change in condition and the results of treatment. Progress notes will be recorded by the person giving the treatment or making the observation. The medical records committee will also assign oversight responsibility for documentation made by other than medical officers who write in the IREC.

(2) Progress Notes by Physicians. In addition to the information described above, physicians' notes, documented on SF 509, must include an analysis of the patient's clinical course. Physicians must outline the rationale for specific medical decisions. Physicians' notes begin with an admission note, continue with notes during hospitalization, and conclude with a final note on discharge or death.

(a) In the admission note, briefly record the clinical circumstances that brought the patient to the hospital. Summarize the proposed diagnostic workup and suggest the type of therapeutic management. For emergency patients admitted, the SF 558, Medical Record-Emergency

Care and Treatment, placed in the IREC may be used as the admission note.

(b) For surgical patients, the admission note may serve as the preoperative note. In addition to giving the information in 16-49(2)(a) above, justify the surgery and state the procedure proposed. If surgery scheduled within 24 hours of admission is not performed within 2 days, the surgeon must write another preoperative note justifying the surgery.

(c) Record the anesthesiologist's or nurse anesthetist's preanesthesia note on an SF 517, Clinical Record-Anesthesia, and SF 509, as appropriate. Explain the choice of proposed anesthesia. In a postanesthetic note, record the presence or absence of anesthesia-related complications.

(d) For the post-operative patient, record in the progress notes the condition of the surgical wound, any indications of infection, and the removal of sutures and drains. Record examinations of chest and legs until ambulatory and afebrile, the use of casts or splints, and any other pertinent data.

(e) At the time of intrahospital transfer, write a note to summarize the course of the patient's illness and their treatment.

(f) Record in the final progress note the patient's general condition on discharge and the final diagnosis. Outline the postdischarge care (including activity permitted, diet, medications, dressings, and the date and clinic for followup care.

(g) In hospital death cases, describe the terminal circumstances, findings, and final diagnosis in the final note. State whether or not an autopsy was done.

(h) The frequency of progress notes depends on the condition of the patient. They should be written every day or as determined by local instructions. For surgical patients, write a daily note for at least the first 4 post-operative days. For convalescent patients and orthopedic patients with no complications, notes will not be needed as often as for patients receiving active treatment. Never allow more than 7 days to pass without a progress note.

(i) When members of the house staff are involved in patient care, document sufficient evidence in the medical record to substantiate the active participation in, and supervision of, the patient's care by the attending physician responsible for the case. The frequency of the attending physician's documentation is determined by local MTF guidelines.

(j) Documentation for release of a newborn or minor child to other than the parents or legal guardian is done in coordination with the MTF's legal advisor. Documentation must include:

(1) Physician's written statement indicating that delivering the newborn or child to the parent or guardian

would be detrimental to the health of the parent, guardian, or child; impractical; and not in the best interest of the parent, guardian, or child.

(2) A signed and notarized statement from the parent or guardian expressing the desire to have another agent or agency receive the newborn or child.

(3) A signed statement from the agent or agency accepting full responsibility for the newborn or child.

(k) Record diagnostic or therapeutic services provided and findings, diagnosis, or therapeutic outcomes not recorded on SF 513. Include significant consultation contacts made with other personnel involved with the patient such as unit commanders, lawyers, teachers, other family members, etc., not recorded on SF 513.

(3) Progress Notes by Nurse Anesthetists, Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants. Record progress notes on the SF 509.

(4) Progress Notes by Nurses. Nurses' notes documented on SF 510 must describe chronologically the nurses' care given the patient. Document progress notes on SF 509 in MTFs where the problem-oriented medical record (POMR) is approved.

(5) Dietetic Progress Notes. Record initial notes on SF 513 and subsequent notes on SF 509.

(6) Physical and Occupational Therapy Notes. Summarize on SF 509 treatment given inpatients. Identify each entry as a physical therapy or occupational therapy note; do not make worksheets a permanent part of the IREC.

(a) The therapist's first IREC entry should be the initial evaluation of the patient recorded on the SF 513. Record the goals of the treatment program and the plan of care.

(b) Later entries should be periodic status reports. Include on the SF 509 the patient's response to treatment and any important changes in the condition or treatment program.

(c) The final summary note must be an evaluation of the therapy given. Include the patient's progress, the degree of goal achievement, and any recommendations for postdischarge care.

(7) Social Service Notes. Social service personnel must record their initial note on SF 513 and subsequent notes on SF 509 Include:

(a) Medico-social study of the patient who needs social services.

(b) Social therapy and rehabilitation.

(c) Social service summary. Identify each entry as a social work entry. Social work case files do not become a part of the patient's IREC.

(8) Psychology Notes. Psychologists will record their notes on SF 509.

(9) Physicians must acknowledge consultive comments in writing on the SF 509. House staff or attending physi-

cians should note on the SF 509 that laboratory, radiology, or other test results have been reviewed.

(10) The POMR is authorized for use.

(a) Local policy should prescribe specific uses of the POMR. The MTF medical records committee should decide:

(1) The types of cases for which the POMR is used (i.e., whether routine cases, long-term, diagnostic problems, etc.).

(2) The category of person (i.e., physicians, nurses, or others using the POMR).

(3) The placement of the problem list in the IREC.

(b) Nurse's progress notes can be recorded on the SF 509 if the POMR is approved.

(c) The POMR must include a summary at the completion of treatment.

## 16-50

### SF 513 Medical Record- Consultation Sheet

(1) The consultant must record the first assessment on the SF 513. Record subsequent visits on the SF 509 in the chronology of care. Consultations relating to occupational health from private physicians or practitioners are filed with the SF 513.

(2) The provider writing the consult must have done a reasonable workup on the patient before making a referral. The workup and clinical diagnosis should be well documented in the medical record. X-ray films, if ordered, or other test results should accompany the SF 513. Be sure the SF 513 is explicit enough for the specialist to determine the urgency.

(3) The patient remains the responsibility of the referring provider until the specialist takes over the care. In some cases, the specialist will perform an examination or procedure and refer the patient back to the original provider for continued care. The medical record should reflect this so that the patient has no doubt as to who is the primary provider of care.

(4) The specialist must always provide a copy of the consult back to the referring provider. The original stays in the medical record.

## 16-51

### SF 516 Medical Record- Operation Report

(1) Dictate the operation report immediately after surgery for all cases involving surgery in the operating room (OR) or ambulatory surgery unit (even when done under local anesthesia and transcribed on SF 516). Local guidance should specify time after surgery by which operative reports should be dictated. File these reports in the medical record as soon as possible after surgery. Describe all procedures performed anywhere other than the OR or ambulatory surgery unit (e.g., ward, clinic, and emergency room in the progress notes, SF 509 for inpatients, or SF 600 for outpatients). Ensure that procedural terminology on the operative report (or progress notes, narrative summary, and cover sheet) are the same.

(2) Include in the report:

(a) The pre and post-operative diagnosis.

(b) The name of the operative procedure.

(c) A full description of the findings, both normal and abnormal, of all organs explored.

(d) A detailed account of the technical procedures used.

(e) Specimens removed.

(f) The condition of the patient at the end of the operation.

(g) Name of the primary surgeon and assistants.

## 16-52

### SF 519, SF 519A and 519B, Medical Record Radiologic Consultation Request/Report

(1) Use SF 519A or 519B to request radiologic, nuclear medicine, ultrasound, or computed tomography examinations. (Use SF 526, Clinical Record-Radium Therapy, to request radium therapy.) When received, staple the original SF 519A or 519B to the assembly sheet, SF 519. The attending physician must verify that they have seen abnormal findings and should verify that they have seen all other findings by initialling the original SF 519 before filing in the medical record. Route the second copy to the requesting practitioner. Do not file carbon copies of radiologic reports in the medical record.

(2) The attending physician must indicate a review of consult findings in the IREC. This can be done by initialing the completed report. If there are abnormal findings this must be acknowledged in the record with evidence of what action or treatment plan was considered appropriate.

**16-53**

**SF 522, Medical Record Request Request for Administration of Anesthesia and for Performance of Operations and Other Procedures**

(1) The surgeon who is to perform the surgery personally makes arrangements for all major surgical operations including the notation of an informed consent on the SF 522. Informed consent should be obtained and documented on all procedures where the risk to the patient is such that the patient should be properly informed prior to performing the procedure. The medical staff should determine which procedures require informed consent. When documenting informed consent, the patient has been informed of the proposed treatments, relevant risks and alternatives, and that their knowing agreement has been obtained. The surgeon makes an entry in the progress report that the procedure and possible complications were discussed with the patient. In cases of divorced or separated parents, the parent with legal custody should consent.

(2) Only in an emergency or when the condition of the patient prevents a meaningful discussion may this be omitted. Such cases should be reviewed under the QA program.

(3) Some anesthesiologists may require *do not resuscitate* (DNR) orders be rescinded before assisting with a surgical procedure. This must be resolved before a patient's condition is compromised by an unresolved difference in medical practice, and documented in the medical record.

**16-54**

**SF 523 Clinical Record-Authorization for Autopsy**

(1) If a post mortem examination is appropriate, for nonactive duty deaths, the attending physician is responsible for obtaining authorization from the next of kin (NOK). If the NOK is present and consents to the post mortem examination, the attending physician must obtain the NOK's signature on three copies of Authorization for Autopsy (SF 523) and sign as a witness. Any restrictions should be carefully and plainly noted on the SF 523; if none are offered, none must be placed in the proper space on the form. Send the SF 523 immediately to the PAD (Officer of the day after working hours).

(2) The NOK is never asked permission for an autopsy when the deceased is an active duty member. The CO of the member or the CO of the hospital has the authority, and in many cases the obligation, to have an autopsy performed.

(3) The medical examiner who has jurisdiction over the area may order an autopsy on any person regardless of military status or religious belief. The Armed Forces Medical Examiner also has jurisdictional rights in certain cases.

**16-55**

**SF 539 Medical Record-Abbreviated Medical Record**

(1) The SF 539 may be used as a substitute for the narrative summary, for those admissions of a minor nature that require 48 hours or less of hospitalization and in the case of normal newborn infants, uncomplicated obstetric deliveries, lacerations, plaster casts, removal of superficial growths, and accident cases held for observation. The SF 539 is not to be used for death cases, admission by transfer of possible medical boards cases, or with complicated short-stay patients. When the SF 539 is used, the narrative summary may be replaced by a final progress note.

(2) The use of the SF 539 negates the requirement for a narrative summary, except in the circumstances listed in article 16-45. The SF 539 must be thoroughly completed in all sections.

(3) The SF 539 may be used when military members are hospitalized for uncomplicated conditions not normally requiring hospitalization in the civilian sector (e.g., measles and upper respiratory infection (URIs)). If the case becomes complicated, then article 16-55(6) applies.

(4) The SF 539 may be used for surgical cases in which general anesthesia was given only if:

(a) The patient is classified as ASA (American Society of Anesthesiologists) Class 1. That is, the patient has no organic, physiologic, biochemical, or psychiatric disturbance. Also, surgery for a pathologic process must be localized and not entail a systemic disturbance.

(b) The patient is hospitalized less than 48 hours. When the SF 539 is used for these cases, the physical examination section must describe fully the cardiopulmonary findings. Do not use terms such as *normal*, *WNL*, and *negative*. Describe any exceptions or other pertinent findings.

(5) When a short stay extends to 48 hours or more, a narrative summary must be prepared. In such cases, SFs 504, 505, and 506 need not be completed in addition to SF 539. The reason for the extended stay will be recorded fully in the progress notes.

(6) When a long stay is expected, but the patient is discharged in less than 48 hours, do not prepare an SF 539 in addition to the SF 504, 505, and 506. The case may be summarized in the progress notes instead of in a narrative summary. In this case, a copy of the SF 504, 505, and 506 and progress notes summary must be included in the HREC or OREC.

## 16-56

### SF 546-557 Laboratory Forms

(1) These forms are used to request laboratory tests and to report the results of those tests. File a copy in the laboratory. Route the original for immediate filing in the IREC, OREC, or HREC and route a second copy to the requesting practitioner.

(2) Authorized computerized laboratory reports may be inserted into the record where the standard forms would ordinarily be filed.

(3) Test results are to be authenticated by initials of an authorized staff member in the laboratory, radiology, or other ancillary service. Laboratory values must be established to require quick notification of the HP and, in turn, the patient. Each testing department or service must establish a standard operating procedure to accomplish abnormal test reporting.

(4) The responsible HP must initial the original test result for abnormal findings before placing it in the record. The requesting HP should also initial all other laboratory reports before placing them in the patient's medical record. This verifies that the HP saw the results. The HP must note abnormal results in the medical record indicating what action, if any, needs to be taken. The ordering physician, not the MTF maintaining the record, is responsible for verifying test results. Test results should not be forwarded to another MTF maintaining the patient's record until they have been verified.

(5) Each MTF must have a coordinated policy for identification of abnormal findings and notification of HPs and patients within established time frames. See article 16-15(4)(d)(9).

## 16-57

### SF 558 Medical Record- Emergency Care and Treatment (Emergency Room Records)

(1) Use SF 558 instead of SF 600 to record all care given to patients in the emergency room.

(2) The record must indicate whether or not the emergency occurred as a result of an on the job injury. If a referral to other sources of health care is made, this action must be stated including the reasons for referral.

(3) When the patient is admitted as an inpatient through the emergency medicine department, the original SF 558 becomes the admission note filed in the patient's inpatient treatment record.

(4) If the patient is not admitted, file original SF 558 in the patient's OREC or HREC. File the first copy in the emergency medicine department and give the third copy of the SF 558 to the patient. Maintain these second copies in a reference file in the emergency medicine department for 2 years; then destroy.

(5) When a patient, such as a civilian emergency, does not have an IREC, OREC, or HREC, send the original SF 558 to the MRB, so that a folder can be made. File the SF 558s in the records folder in the MRB and retire in 2 years with the other ORECs.

(6) If a patient arrives at the emergency medicine department via ambulance, all treatment given in the ambulance or at the scene of the illness or injury must be documented on the Record of Ambulance Care attached



to the SF 558. State or locally developed forms may be used.

(7) Acute care clinics may not use the SF 558. The SF 558 is authorized for emergency medicine department use only, since use of this form presumes a higher level of care. An acute care clinic may want to develop an overprint to the SF 600 to ensure complete documentation of the problem and care provided.

## 16-58

### SF 600 Health Record- Chronological Record of Medical Care

(1) The SF 600 is a form used for outpatient care which provides a current, concise, and comprehensive record of a patient's medical history. Use the SF 600 for all outpatient care and file in the HREC or OREC. Record all visits, including those that result in referrals to other MTFs, on the SF 600. Do not use it for inpatient care. Each person making an entry on the form must sign the entry and print identification information, or use an identification stamp.

(a) Completion of the SF 600. Date each entry in the DD-MMM-YY format (e.g., 03 Feb 93). Type or stamp the name and address of the treatment activity and the entries when practical. When a new SF 600 is initiated, complete the identification block with the name (last, first, middle initial); sex (M or F); date of birth (DD-MMM-YY); component or status (active duty, Reserve, retired or civilian employee); if applicable, service (USN, USMC, etc.); FMP and sponsor's SSN (followed by the designator code or MOS for officers); and the member's grade or rate and organization at the time the form is completed, if applicable. Verify these entries carefully, especially the first time the patient visits the MTF, because future handling and filing of the record will be based on the information recorded.

(b) Use both sides of each sheet. Preparation of a new SF 600 is not necessary each time the person is seen in a different MTF. If only a few entries are recorded on SF 600 at the time of a move, stamp the designation and location of the receiving MTF below the last entry and use the rest of the page to record subsequent visits. If the back of the SF 600 is not used, then the back must be crossed out and the words: *This side not used*, printed in the middle of the record. If the name of the MTF is included on the physician's stamp, it is not necessary to use an additional stamp to record the designation and location of the recording medical unit.

(2) The subjective complaint, observation, assessment, and plan (SOAP) for treatment format may be used for entries so long as the required information, per article 16-58(3) below, is included.

(3) Enter the following information in the patient's medical record for each outpatient visit.

(a) Date. A complete date must included with every entry in the medical record. When an undated page is misfiled, it is difficult to replace in proper sequence. Use the three letter abbreviation for the month on all dates (e.g., 27 Jun 90).

(b) MTF name. Name of hospital, ship, or clinic.

(c) Clinical department or service.

(d) HP's name, grade or rate, profession, (for example, PT, DDS, MD or corps, and SSN).

(e) Chief complaint or purpose of visit.

(f) Objective findings.

(g) Diagnosis or medical impression.

(h) Studies ordered and results, such as laboratory x-ray or x-ray studies.

(i) Therapies administered.

(j) Disposition, recommendations, and instructions to patient. Include rationale, exposure data, findings, etc., when an individual is enrolled or removed from an MSP (Medical Surveillance Program).

(k) Signatures or initials of practitioners.

(4) Record each visit and the complaint described even if a member is returned to duty without treatment. Document if a patient leaves before being seen.

(5) When admission as an inpatient is imminent, the entries discussed in article 16-58(3) above may be made on SF 509 (Medical Record-Progress Notes), instead of SF 600. This will be the inpatient admission note filed in the patient's IREC. Record referred or deferred inpatient admissions on SF 600.

(6) When the SF 509 is used, make an entry on the SF 600 that the patient was seen in (clinic name).

(7) Overprints on the SF 600 are authorized at the local level. See article 16-15(5).

(8) Record all requests for consultations (also record on SF 513), prescriptions, or other services on an SF 600.

(9) When patients are seen repeatedly for special procedures or therapy (e.g., physical and occupational therapy, renal dialysis, or radiation), note the therapy on SF 600 and record interim progress statements. Initial notes, interim progress notes, and any summaries may be recorded on any appropriate authorized form but must be referenced on SF 600. Write a final summary when the special procedures or therapy are ended. Include:

(a) Results of evaluative procedures.

(b) Treatment given.

(c) Reaction to treatment.

(d) Progress noted.

(e) Condition on discharge.

(f) Any other pertinent observations.

(10) If this is the initial treatment for an injury, enter the cause and circumstances (how, when, where, and leave status).

(11) For persons taking part in research projects as test subjects, entries must include:

(a) The drugs given or appropriate identifying code.

(b) Investigative procedures performed.

(c) Significant observations, including effects.

(d) The physical and mental state of the subject.

(e) Test and laboratory procedures performed.

(12) Record each referral to sick in quarters (SIQ) on SF 600. Make detailed comments on:

(a) Care given.

(b) Estimated duration.

(c) Extensions of quarters status.

(d) When the patient will be returned to duty.

(e) Laboratory, x-ray, consultation, and similar reports.

(13) Sick Call Treatment Entries

(a) Whenever a member is evaluated at sick call, make an entry on the SF 600 including information listed in article 16-58(12). In the event of injury or poisoning, record the duty status of the member at the time of occurrence and the circumstances of occurrence per the guidelines in BUMEDINST 6300.3 series.

(b) When a member of the naval service incurs an injury, which might result in a permanent disability, or physical inability to perform duty for a period exceeding 24 hours, make an entry which includes specific facts about time, place, names of persons involved, and circumstances surrounding the injury.

(c) Whenever outpatient treatment is furnished to a member whose HREC is not available, report the information on SF 600.

(14) Binnacle List and Sick List Entries

(a) When a member's name is placed on the binnacle list for treatment, make an entry on the SF 600 showing date, diagnosis, and a summary of treatment.

(b) When an active duty member is placed on the Sick List, the medical department representative must enter information on the SF 600 about the nature of the disease, illness, or injury; pertinent history or circumstances of occurrence; treatment rendered; and disposition.

(15) The Blood Grouping and Typing Record. A locally developed SF 600 overprint may be used as a blood grouping and typing record.

(a) Information on the Blood Grouping and Typing Record identifies the individual by the appropriate ABO group and Rh type (positive or negative). Testing results

shall be indicated on the form and the original request filed with the SF 545 in the member's record.

(b) The Blood Grouping and Typing Record may also contain a syphilis screening test and other screening tests for the presence of certain disease conditions.

(16) Entries for Physical Examinations. Enter the term Physical Examination and the date on SF 600 for each complete physical examination conducted and recorded on SF 88. Do not enter entrance medical examinations.

(17) Entries for Orthopedic Footwear. Enter the phrase Orthopedic Footwear Authorized on SF 600 when issuance is authorized. Also enter the prescription and date.

(18) Entries for Drug Abuse Treatment. Make an entry on SF 600 when a person is judged to be an alcohol or other drug abuser as the result of a clinical evaluation.

(19) Record dental treatments on SF 600 whenever the conditions in chapter 6 are met.

(20) Allergy Treatment. The OREC of a patient treated for an allergy must contain the record of the initial evaluation, including history, sensitivity studies, and recommended treatment. The allergy clinic personnel must record followup desensitization treatment on an SF 600. An overprint may be used. Enter immediately any significant reaction finding or change in plan of treatment in the OREC or HREC. MTFs that compound their own vaccines must use local prescription formats which reflect appropriate dosage schedules. MTFs that are serviced by the Walter Reed Army Medical Center Allergen Preparation Laboratory must use SF 559, Medical Record-Allergen Extract Prescription-New and Refill.

(21) Document any hypersensitivity to drugs or chemicals known to exist on a separate SF 600. Annotate at the bottom of the form the words Special-hypersensitivity. (Also record hypersensitivities on the SF 601, SF 603, NAVMED 6150/10-19, and the NAVMED 6150/20.)

(22) When a member of the naval service is injured or contracts a disease while on leave, or when circumstances surrounding an injury or sickness have not been entered in the individual's HREC, the physician or medical department representative having custody of the record must collect information and make the necessary entries.

(23) For all Naval Reserve personnel checking onto, or off of orders (annual training (AT), active duty for training (ADT), inactive duty training travel (IDTT)), the following statements must be placed on the SF-600 and signed by the member along with the MDR.

(a) For personnel checking onto orders:

I certify there have been no significant changes in my physical condition since my last physical examination or annual certification. Furthermore, I certify that I have no illness or injury that would preclude me from performing this period of (circle one) AT, ADT, IDTT.

(b) for personnel checking off of orders:

I certify that I have/have not incurred or aggravated any injuries or illnesses during the period of Naval Reserve service.

Member's signature with date.

Medical Department representative signature and date.

**16-59**

**SF 601  
Health Record-  
Immunization  
Record, and  
PHS-731  
International  
Certificates of  
Vaccination**

(1) The SF 601 is used to record information regarding prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food, and allergies; and blood typing. Information is recorded in the appropriate block of the current SF 601 until space is exhausted in any single category. When this occurs, prepare a new SF 601 and file in the HREC chronologically. Verify previous entries and bring the most current immunizations forward. Retain the old SF 601 beneath the new SF 601. Replacement of the SF 601 is not required due to a change in grade, rating, name, or status of the member. Never maintain the SF 601 separate from the HREC.

(2) Prepare and maintain an immunization record (SF 601) for each person with a HREC or OREC. Information recorded on the SF 601 is normally needed for Government international travel (i.e., unit deployments or directed Government travel).

(3) Preparation and use of SF 601 for Dependents. Put the SF 601 into the record when:

- (a) The OREC is initiated.
- (b) The patient reports for immunization or sensitivity tests.
- (c) Reactions are noted.

(4) Ensure that all entries are accurately recorded on the SF 601.

(5) Prepare the PHS-731 form and issue to patients for custody when needed for independent international travel. This form is a personal record of immunizations received and is normally needed for international travel. Do not file the PHS-731 in the medical record at any time. Ensure all entries are accurately entered on the SF 601 and transcribed to the PHS-731. The following information is required on the PHS-731:

- (a) The patient's name on the Traveler's Name line.
- (b) Address:

(1) Navy members: Bureau of Naval Personnel, Arlington Annex, Washington, DC 20370-5000.

(2) Marines: Office of the Commandant of the Marine Corps, Headquarters, U.S. Marine Corps, (Code MMSB-10), 2008 Elliott Road, Suite 201, Quantico, VA 22134-5030.

(3) Others: The patient's home address.

(6) Responsibilities

(a) Unit commanders must ensure that each assigned or attached member receives the immunizations required. The immunization status of each unit member must be checked periodically (at least annually, or just prior to deployment). Consultation with the local medical officer may be necessary to ensure that immunizations are given when due.

(b) The unit personnel officer, acting on behalf of the commander, must notify members when immunizations are required.

(c) The HP must check the accuracy of the entries on the SF 601 as well as administer immunizations and tests. Complete all entries in the appropriate section of SF 601, including required entries on reactions, and authenticate required immunizations.

(7) Authentication of Entries for OCONUS Deployment (except shipboard). Per international rules, authenticate entries on SF 601 for immunizations against smallpox, yellow fever, and cholera. Each entry must show the DoD immunization stamp. The signature block may be stamped or typewritten and authenticated by HP signature.

(8) Entries. Record immunizations and sensitivity tests on SF 601. Indicate information about hypersensitivity to a drug or chemical under Remarks and Recommendations. Make appropriate entries (such as Hypersensitive to Aspirin, or Hypersensitive to Procaine) on these forms in addition to a Special Hypersensitivity entry required on SFs 603 and 600, and the NAVMED 6150/20 retained in the HREC or OREC.

(9) Disposition or Separation from Service. When the member is released from active duty or separated from the service, the SF 601 should remain with the OREC or HREC.

(10) See NAVMEDCOMINST 6230.3 series for further direction.

**16-60**

**NAVMED 6100/1  
Medical Board  
Report Cover  
Sheet**

(1) Place the original of the NAVMED 6100/1, Medical Board Report Cover Sheet, into the HREC with the corresponding medical board report. All medical board reports are required to be filed in the HREC. These reports consist of: limited duty medical boards, abbreviated temporary limited duty medical boards, temporary limited duty medi-

cal boards, extensions to limited duty medical boards, permanent physical disability medical boards, addendums to medical boards and (for officers) full duty medical boards.

---

**16-61****NAVMED 6150/2  
Special Duty  
Medical Abstract**

(1) NAVMED 6150/1 is a record of physical qualifications, special training, and periodic examinations of members designated for performance of special duty, such as aviation, submarine, and diving. The objective of the special duty examination is to select only those individuals who are physically and mentally qualified for such special duty, and to remove those special duty members who may become temporarily or permanently unfit. Special pay disbursements are often based on the determination of a member's physical and mental qualifications or continued requalification for performance in a special duty. Accuracy and content are essential in the reporting of information for these categories.

(2) Entries

(a) Record the entries after each physical examination and after designated special training. When a previously qualified member is suspended from special duty for physical reasons, enter the period of suspension and the reason on the NAVMED 6150/2.

(b) The scope of the physical examination and technical training prescribed for these special categories often differ from the general service requirements. Entries, reporting results of these examinations or training, must be approved by medical officers or specialty designated medical service corps officers who are familiar with their scope and nature (i.e., aerospace physiologist for aerospace physiology training). Results of special examinations and documentation of training may be transcribed from official records to the NAVMED 6150/2 by the senior medical department representative assigned to ships or stations independent of a medical officer.

(3) Disposition. Retain NAVMED 6150/2 as a permanent part of the HREC.

---

**16-62****NAVMED 6150/4  
Abstract of  
Service and  
Medical History**

(1) The NAVMED 6150/4 provides a chronological history of the ships and stations to which a member is assigned for duty and treatment and an abstract of medical history for each admission to the Sick List.

(2) Entries

(a) Ship or Station column. Enter the name of the ship or activity to which a member is attached for duty or treatment.

(b) Diagnosis, Diagnosis Number, and Remarks column. Enter the diagnosis title and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code number each time final disposition from the Sick List is made.

(c) Date column. Indicate in the From and To sub-columns all dates of reporting and detachment for duty or dates of admission and discharge from Sick List. Upon transfer for temporary duty, make an entry only if the HREC is to accompany the individual to the place of temporary duty.

(3) Disposition. Retain NAVMED 6150/4 as a permanent part of the HREC. Make an entry upon closure indicating the date, title of servicing activity, and explanatory circumstances.

---

**16-63****NAVMED 6150/20  
Summary  
of Care**

(1) All medical records will contain a summary list of relevant conditions and medications that significantly affect the patient's health status. This list provides a concise overview of the patient's medical status, including information relative to health surveillance and health maintenance.

(2) The NAVMED 6150/20 will remain a permanent part of HRECs and ORECs. It will always be the top most form on the left side of all medical records (except IRECs).

(3) Document on the NAVMED 6150/20 the past significant surgical procedures and past and current diagnoses or problems. Do not repeat problems or diagnoses that recur during ongoing treatment.

(4) Responsibility

(a) All physicians and other licensed independent health care practitioners (LIHP) providing care to patients bear responsibility for ensuring the Summary of Care form (SCF) is continuously updated following this manual. Failure to maintain a current, comprehensive listing of all significant diagnoses, medications, and conditions eliminates the value of the SCF as a tool for ensuring continuity of care and may actually result in harm to the patient if an inaccurate SCF is relied upon. Privileged LIHPs are authorized to diagnose, initiate, alter, or terminate health care treatment regimes in naval MTFs. Potential privileged LIHPs include: physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical social workers, clinical psychologists, physician assistants, physical therapists, occupational therapists, audiologists, clinical dietitians, clinical pharmacists, and speech pathologists.

(b) Nonlicensed health care providers are authorized to enter information on the SCF under the following guidelines.

(1) Privileged nonphysician providers may make entries of historical clinical data which is already documented in the chart without mandatory consultation with a physician. Consultation with a physician is required in conjunction with the NAVMED 6150/20 of newly diagnosed or newly documented problems.

(2) On shipboard and at isolated duty stations where an LIHP is not available, nonlicensed health care providers (i.e., physician assistants, hospital corpsmen, etc.) may record significant problems. In all such instances, a review of the NAVMED 6150/20 will be incorporated in the HREC review during routine visits by physician or other LIHP supervisors.

(3) Nurses, physician assistants, hospital corpsmen, and medical clerks/technicians are authorized to enter data concerning documented allergies and all information listed in the health maintenance section. This information must be reviewed by the privileged provider overseeing the patient's care.

(5) NAVMED 6150/20 includes, but is not limited to:

- (a) Significant surgical and invasive conditions.
- (b) Significant medical diagnosis and conditions.
- (c) Known adverse and allergic reactions to drugs.
- (d) Current or recent medications.

(6) A NAVMED 6150/20 is initiated for each patient at the time of the initial visit for care. If the patient has no condition warranting entry on the NAVMED 6150/20, the statement Negative Review may be entered.

(a) The initial NAVMED 6150/20 includes items based on any initial medical history and physical examination.

(b) The NAVMED 6150/20 is updated to facilitate locating relevant information in the medical record.

(c) When significant information concerning the patient is located in another record, a written notation of the relevant item on the NAVMED 6150/20 indicates where the other information is located.

(d) A health status questionnaire may be used to facilitate obtaining the initial information which needs to be entered on the NAVMED 6150/20. While this questionnaire may help obtain information from the patient, it is not a substitute for a NAVMED 6150/20 appropriately completed by an authorized provider. It does not relieve the provider of the responsibility for timely, accurate completion of the NAVMED 6150/20.

(7) Completion of the NAVMED 6150/20

(a) Patient identification data must be completed on each form.

(b) The NAVMED 6150/20 shall include, at a minimum, the following:

(1) Significant medical conditions. This includes chronic diseases (such as hypertension, diabetes, arthritis, alcohol abuse, etc.) and acute recurrent illnesses (such as recurrent urinary tract infection, recurrent otitis media, recurrent vaginitis, recurrent bronchitis, etc.).

(2) Significant surgical conditions. This includes all procedures requiring general or regional anesthesia and any procedures likely to have a long-term effect on the patient's health status.

(3) Blood type, G6PD, and sickle cell trait must be completed as initial entries under health surveillance. These entries may be made by appropriately trained clerical or technical personnel.

(4) Occupational health surveillance activities such as Asbestos Program, Hearing Conservation Program, lead exposure, etc., will be listed in the health surveillance section.

(5) Any allergies or untoward reactions to drugs should be noted in the medical alert section.

(6) Record all currently or recently used medications.

(7) The date of the health maintenance functions listed in this section should be entered in pencil. This will facilitate erasure and expected updating.

(c) Only approved abbreviations will be used on the NAVMED 6150/20.

(d) NAVMED 6150/20 entries must be legible.

(e) Significant medical and surgical conditions must be listed clearly and concisely. The NAVMED 6150/20 is not meant to be a sick call log. Questionable or problem diagnosis, rule outs (i.e., rule out pneumonia, gastroenteritis, viral syndrome, etc.) and routine complaints (such as upper respiratory infections, single episode of urinary tract infections, etc.) should not be on the NAVMED 6150/20. Occupational health program documentation, including the date the employee is enrolled and terminated from

specific programs, must be documented on the NAVMED 6150/20. Documentation may be completed by the occupational health nurse, or other occupational HP in the occupational health department.

(f) As new conditions are identified, the provider should add them to the list and enter the date in the appropriate column.

(g) As conditions resolve or become inactive, this status should be noted above the statement of the problem, and the date added to the date column.

(h) The NAVMED 6150/20 should be reviewed and revised as necessary at the time of each patient visit.

(i) If the NAVMED 6150/20 becomes damaged and must be replaced, information from the original may be transcribed to the new form by hospital corpsmen or medical record personnel, but the transcription must be verified against the original by responsible individuals designated by the commanding officer. Where there is any question concerning accuracy or interpretation of information, clarification by a physician or other privileged provider must be obtained. The original form may be discarded only when all information on the form has been transcribed and verified on the new form.

(8) Review contents during yearly HREC verification and before transfer of HRECs.

## 16-64

### NAVMED 6300/5 Inpatient Admission/ Disposition Record

(1) The purpose of the NAVMED 6000/5, which is generally a computerized form, is to record the administrative and diagnostic information about the admission, diagnosis, treatment, and disposition of an inpatient. The initial information is obtained at the time of admission or is updated if the patient is already registered in AQCESS or CHCS.

(2) An admission may be canceled by the attending physician in cases where the patient has not physically been placed in a bed and received any care, treatment, or a diagnostic workup.

(a) The cancellation is an occurrence screen for risk management.

(b) The admission number should be reused, if the MTF's system allows this to be done.

(c) Note the reason for cancellation in the record and forward pertinent documentation to the OREC or HREC of the patient.

(3) When a patient is readmitted within a 24-hour period, cancel the discharge and reopen the patient's IREC.

(4) This form includes the attestation statement which the physician signs after discharge.

## 16-65

### DD 602, Patients Evacuation Tag

(1) This form is the patient's in-transit medical record. The attending physician prescribes enroute medical requirements on this form before the patient departs the originating MTF, and all enroute treatments are noted on the form during the patient's journey. The tag consists of the Ship's Record Office Tab, the Embarkation Tab, and the Debarkation Tab. Only the basic tag is normally required.

(2) Refer to BUMEDINST 6320.1 series. All patients, regardless of age, and attendants under 10 years of age must wear a Patient Identification Band, while in the aeromedical evacuation system.

(3) The originating medical MTF prepares DD 602, entering all pertinent information except Cabin or Compartment No. This information, when required, is entered by the carrier representative. If a patient's journey is in several stages, enroute staging facilities will use the original tag for recording pertinent medical data and forward it with the patient when he or she departs for the next leg of the journey.

(a) Enter all diagnoses, including only such detail as will be useful in caring for the patient during the journey.

(b) In the Diagnosis section, enter in red pencil the terms:

(1) Prisoner, for patients in a prisoner status.

(2) Summary of Care Under Investigation, for patients who are under investigation (but not formally charged) for a serious crime.

(3) DA, for patients with a history of drug abuse.

(c) Check the space battle casualty only if the patient actually falls into this category as defined in governing regulations. Patients who are not battle casualties, but under treatment primarily for nonbattle wounds or other injuries will be classed as Injury.

(d) Enter the same baggage tag numbers as shown on DD 602.

(e) Enter treatment recommended enroute in the space provided. Enroute medication, with dosage as prescribed by the attending physician, must be recorded in this section. If a patient requires tube feeding, a copy of the tube feeding formula must be attached to DD 602 to assure the patient receives the same tube feeding throughout the journey.

(f) Use the reverse side to note enroute examinations and treatment, where such information is not of sufficient importance to justify opening the patient's clinical records. Enter treatment administered at enroute medical facilities or aeromedical staging facilities, as well as that treatment provided by the carrier. In addition, enter in this section, preferably by means of rubber stamps, the name of the MTF, and the dates of the patient's arrival and departure. These dates, in prescribed sequence, need not be identified. All treatment entries will be accompanied by the time that such treatment was actually administered. Times must be recorded in Greenwich mean time, indicated by the use of the suffix Z.

(4) Disposition of DD 602. The final destination hospital will insert the basic tag of DD 602 in the patient's clinical records. For outpatients, insert DD 602, in the HREC, OREC, or DREC, as appropriate. The embarkation tab and debarkation tab may be immediately disposed of locally.

## 16-66

### DD 771 Eyewear Prescription

(1) This form is used to order corrective prescription eyewear and record information required to order eyeglasses.

(2) When receiving prescription eyewear from the ophthalmic laboratory, retain copy 2 of the DD 771 in the patient's HREC or OREC.

(3) If the DD 771 is the only documentation of the eyewear prescription in the medical record, mount it on an SF 600.

## 16-67

### Fetal Monitoring Strips

(1) Use the following procedures for maintaining fetal monitoring strips (FMS):

(a) Keep the strips on the obstetrical unit with the prenatal record until delivery occurs.

(b) When delivery occurs, put the following information on envelopes that contain the fetal monitoring strips:

(1) Name and register number of infant. If the infant has not been named, record baby boy or baby girl with the last name.

(2) Sponsor's name and SSN.

(3) Name and date of birth.

(c) Place the FMS inside the envelope.

(d) When the infant is discharged, send the monitoring strips to the MRB.

(2) Use either of these disposition procedures:

(a) Mount the FMS envelopes on the top, left side of the infant's IREC. For nonviable infants, place the FMS in the IREC of the mother. Retire the FMS with the original IRECs, or

(b) Maintain the FMS in envelopes as a separate file in SSN sequence in the MRB. Add the infant's FMP to the sponsor SSN on the locator card and on the envelope. Annotate information regarding location of the FMS in the IREC of the infant and the mother. Place the FMS envelopes in fiberboard boxes used to retire records. (For example, file two rows of 6 1/2 by 9 1/2 inch envelopes in these boxes. Staple the locator card received from admissions on the outside of the envelope. Write the register number of the infant at the top of each envelope where it will be clearly visible when envelopes are filed in boxes for retirement. The maximum use of filing space is possible when envelopes are arranged in two rows in the boxes). Retain FMSs under the original register number of the infant.

(c) The following are special cases:

(1) Transfer of Undelivered Patient. In these cases, prepare and send all FMSs with the IREC.

(2) Transfer of Newborn. Forward the FMSs with the patient when a newborn infant is transferred during initial hospitalization.

(3) Stillborn Infants. File FMSs under the mother's FMP and the sponsor's SSN.

(4) Other Special Cases. When it cannot be determined that prenatal care terminated in hospitalization or delivery, send the outpatient FMPs to the MRB. File these strips by sponsor SSN.

(3) Retire fetal monitoring strips in SSN sequence (exception: article 16-67(2)(d)).

(4) Maintenance of FMPs in microform format must receive BUMED (MED-335) approval.

---

## **16-68**

### **Record of Ambulance Care**

(1) Use a State or locally developed form to document all treatment given in the ambulance or on the scene of the illness or injury. Retain the original record of ambulance care in the OREC or HREC if the patient is not admitted and in the IREC for admitted patients. Use state ambulance forms if available. Where state forms are not available, use locally developed forms. Attach the record of ambulance care to the SF 558.

---

## **16-69**

### **Deoxyribonucleic Acid (DNA) Sample Medical Record Pouch**

(1) The specimen collection consists of two individualized bloodstain cards, for collection of blood droplets from

a finger stick (any finger except the right index finger) or a venipuncture, with an accompanying location for the right index fingerprint impression, identifying data including name, date, social security number, branch of service, and the members' signature, bar coded labels for specimen identification. Humidity barrier pouches (a medical record pouch) and an Armed Forces Institute of Pathology (AFIP) barrier pouch with desiccant and an oral swab vial with preservative are also included.

(2) One of the bloodstain cards and a desiccant pouch should be placed in a bar coded medical record pouch. The pouch should be labeled DNA Reference Specimen. This pouch should be filed as the bottom most page of the left side of the service member's HREC, using the pre-punched holes on the pouch. A dated medical record entry to include the name of the activity will be typed or stamped on the SF 601 in the HREC stating DNA Reference Specimen obtained. Signature is not required.

(3) The second bloodstain card with a desiccant pouch should be placed in one side of the bar coded AFIP double pouch. The oral swab should be placed in the second side of the pouch. The AFIP double pouch will be sent to the DoD specimen repository site, by registered mail, for inclusion as part of the DoD Specimen Registry.

(4) The use of venipuncture and vacutainer tubes for sample collection is optional.

(5) DNA specimen kits are available from the Armed Forces Institute of Pathology. Orders can be placed telephonically at (301) 295-1141, or write to: Armed Forces Institute of Pathology, DoD DNA Repository, Attn: Supplies Reorder, 16050 Industrial Drive, Suite 100, Gaithersburg, MD 20877. Commercial 301-295-4379/4381.



# Section VIII

## Abbreviations, Acronyms, and Definitions

---

ADAPCP	Alcohol and Drug Abuse Prevention and Control Program	EMT	Emergency Medical Technician
AFIP	Armed Forces Institute of Pathology	FAP	Family Advocacy Program
AMSP	Asbestos Medical Surveillance Program	FAR	Family Advocacy Representative
ARC	Alcohol Rehabilitation Center	FCSE	Federal Civil Service Employee
ART	Accredited Record Technician	FMP	Family Member Prefix
ASA	American Society of Anesthesiologists	FMS	Fetal Monitoring Strip
AQCESS	Automated Quality of Care Evaluation Support System	FOIA	Freedom of Information Act
AWOL	Absent Without Leave	GSA	General Services Administration
BCNR	Board for Correction of Naval Records	HIV	Human Immunodeficiency Virus
BUMED	Bureau of Medicine and Surgery	HM	Hospital Corpsman
BUPERS	Bureau of Naval Personnel	HP	Health Care Professional-An individual who has special training or education in a health-related field. This may include administration, direct provision of patient care, or ancillary services. Such a professional may be licensed, certified, or registered by a Government agency or professional organization to provide specific health services in the field as an independent practitioner or employee of a health care facility.
CCU/ICU	Cardiac Care Unit/Intensive Care Unit	HREC	Health Record
CD	Considered Disqualifying	ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
CEPR	Civilian External Peer Review	ID	Identification
CFR	Code of Federal Regulations	IDC	Independent Duty Corpsman
CHCS	Composite Health Care System	IREC	Inpatient Record
CMC	Commandant of the Marine Corps	ISIC	Immediate Supervisor in Command
CNO	Chief of Naval Operations	JCAHO	Joint Commission on Accreditation of Healthcare Organizations
CO	Commanding Officer	Lab Tech	Laboratory Technician
CT	Computerized Tomography	LPN	Licensed Practical Nurse
CY	Calendar Year	MCRS	Marine Corps Recruiting Station
DD-MMM-YY	Day-Month-Year	MD	Medical Doctor
DDS	DEERS Dependent Suffix	MEPS	Military Entrance Processing Station
DD	Department of Defense	MIA	Missing In Action
DEERS	Defense Enrollment Eligibility and Reporting System	MOS	Military Occupational Specialty
DIS	Defense Investigative Service	MRA	Medical Record Administrator
DNA	Deoxyribonucleic Acid	MRB	Medical Records Branch
DNR	Do not Resuscitate	MRI	Magnetic Resonance Imaging
DoD	Department of Defense	MRPF	Merged Records Personnel Folder
DON	Department of the Navy		
DREC	Dental Record		
DTF	Dental Treatment Facility		
DVA	Department of Veterans Affairs		
ECMS	Executive Committee of the Medical Staff		
EFM	Exceptional Family Member		
EKG	Electrocardiogram		
EMF	Employee Medical Folder		

MSP	Medical Surveillance Program	PRIMUS	Primary Care for the Uniformed Services
MTF	Medical Treatment Facility	PRP	Personnel Reliability Program
NAMI	Naval Aerospace Medical Institute	PSD	Personnel Support Detachment
NAVCARE	Navy Cares	PT	Physical Therapist
NAVJAG	Navy Judge Advocate General	QA	Quality Assurance
NAVMED	Navy Medical	Rep	Representative
NAVPERS	Navy Personnel	RET. YR. TAPE	Retirement Year Tape
NAVSUP	Navy Supply	Rh	Rhesus Factor
NHSD	Naval Health Sciences Division	RHO	Radiation Health Officer
NCD	Not Considered Disqualifying	RN	Registered Nurse
NEHC	Naval Environmental Health Center	ROM	Range of Motion
NH	Naval Hospital	ROTC	Reserve Officer Training Corps
NIS	Naval Investigative Service	RRA	Registered Records Administrator
NMPC	Naval Military Personnel Command	SECNAV	Secretary of the Navy
NOAA	National Oceanic and Atmospheric Administration	SF	Standard Form
NOHIMS	Navy Occupational Health Information Management System	SIQ	Sick in Quarters
NOK	Next of Kin	SOAP	Subjective, Observation, Assessment and Plan
NPRC	National Personnel Records Center	SSIC	Standard Subject Identification Codes
NROTC	Naval Reserve Officer Training Corps	SSN	Social Security Number
NRPC	Naval Reserve Personnel Center	TB	Tuberculosis
NSN	National Stock Number	TDFS	Terminal Digit Filing System
NTC	Naval Training Center	TD-SSN	Terminal Digit-Social Security Number
Nuc. Med.	Nuclear Medicine	TM	Training Manual
OB	Obstetrical	U/I	Units/Items
OCONUS	Outside of the Continental United States	UA	Unauthorized Absence
OIC	Officer in Charge	URI	Upper Respiratory Infection
OPF	Official Personnel Folder	USA	United States Army
OPNAV	Office of the Chief of Naval Operations	USC	United States Code
OR	Operating Room	USCG	United States Coast Guard
OREC	Outpatient Record	USMC	United States Marine Corps
OSHA	Occupational Safety and Health Administration	USN	United States Navy
PAD	Patient Administration Department	USPHS	United States Public Health System
PARA	Paraprofessional-A trained aid who assists a professional person.	UTI	Urinary Tract Infection
PHS	Public Health Service	VAMC	Veterans Administration Medical Center
PL	Public Law	WNL	Within Normal Limits
POMR	Problem-Oriented Medical Record	WRAMC	Walter Reed Army Medical Center
POW	Prisoner of War	YY-MMM-DD	Year-Month-Day