

CHAPTER 12

HEALTH RECORDS

Just as the Personnelman is responsible for the preparation and maintenance of the service record, so you, the Hospital Corpsman, are responsible in the same way for health records. A health record is the official medical history of Navy and Marine Corps personnel and eligible beneficiaries.

The military health record is an individual's chronological record of medical, dental, occupational health evaluations, and treatments. The health record is used by healthcare providers to plan and document patient care treatment. The medical history provided by the health record assists medical personnel who perform physical examinations, physical fitness evaluations, diagnosis decisions, and render care incident to injury or disease.

The health record has significant medicolegal value to the patient, the medical treatment facility (MTF) and dental treatment facility (DTF), the practitioner responsible for the patient, and the U. S. Government. For example, if a military member or eligible beneficiary is injured by a nonmilitary individual (e.g., car accident) and the naval hospital provides medical care, the naval hospital would, in turn, bill the nonmilitary individual or his insurance company (third-party payer) for the medical services it provided the injured military member or beneficiary. To justify the naval hospital's billing, send copies of medical documents from the injured individual's health record pertaining to the injury and subsequent treatment(s) to the third-party payer. Third-party payers depend substantially upon the information recorded in the medical record. Also, various officials and boards (i.e., special duty boards and medical boards) refer to information furnished by the health record in determining physical fitness or physical disability.

The health record provides statistical data for medical research, utilization management, risk management, and quality assurance. For all the reasons mentioned here, accurate and complete record entries and proper medical record maintenance are of the utmost importance.

This chapter will discuss the requirements for opening, maintaining, verifying, and closing active

duty and reserve personnel health records. Use of medical forms and form filing procedures will also be covered. For further details and up-to-date guidelines on health record management, as well as differences between medical records established by deployable units or under combat conditions, refer to chapter 16 of the *Manual of the Medical Department* (MANMED) and pertinent instructions or notices.

PRIMARY AND SECONDARY MEDICAL RECORDS

LEARNING OBJECTIVE: *Identify the various types of primary and secondary medical records, and recall the usage of each type.*

Primary medical records are the original records established to document the continuation of care to service members (active and retired) and their beneficiaries. Secondary medical records are established by a patient's healthcare provider and contain specific medical information needed by that healthcare provider. Secondary medical records are maintained separate from the primary medical record.

PRIMARY MEDICAL RECORDS

Three major categories of primary medical records are health records (HRECs), outpatient records (ORECs), and inpatient records (IRECs). Dental records (DRECs) are part of HRECs and ORECs.

Health Record

The HREC is a file of continuous care given to **active duty members** and documents all their outpatient care. While the HREC primarily documents ambulatory (outpatient) care, copies of inpatient narrative summaries and operative reports are also placed in the HREC to provide continuity of healthcare documentation.

Outpatient Record

The OREC is a file of continuous care that documents ambulatory treatment received by a person other than an active duty person.

Inpatient Record

The IREC is a medical file that documents care provided to a patient (inpatient) assigned to a designated inpatient bed in an MTF or ship.

SECONDARY MEDICAL RECORDS

Secondary medical records are separate from the primary medical record and must follow the guidelines established by the MANMED and the local medical records committee. These records are kept in a separate file secured in a specialty clinic or department of fixed MTFs (e.g., naval hospitals and branch medical clinics). The secondary medical records include convenience records, temporary records, and ancillary records.

Because primary healthcare providers of active duty personnel must be aware of their crew's medical status at all times, temporary and ancillary records will not be opened or maintained for active duty personnel. The exceptions to this policy are records for obstetrics/gynecology (OB/GYN), family advocacy, and psychology and psychiatry clinical records.

The healthcare provider creating a secondary medical record should write a note stating the nature of the secondary record, the patient's diagnosis, and the clinic or department name, address, and telephone number on the NAVMED 6150/20, *Summary of Care*, of the patient's primary medical record. The healthcare provider should make a second note entry on the NAVMED 6150/20 when the secondary record is closed.

Convenience Record

A convenience record contains excerpts from a patient's primary record and is kept within the MTF by a treating clinic, service, department, or individual provider for increased access to the information. When the convenience record's purpose has been served, the establishing clinic, service, department, or provider purges the record from its file, compares it to the primary medical record, and adds any medical documents that are not already in the primary medical record.

Temporary Record

A temporary record is an original medical record established and retained in a specialty clinic, service, or department in addition to the patient's primary

medical record. Its purpose is to document a current course of treatment. The temporary medical record becomes a part of the primary medical record when the course of treatment is concluded. This record is most commonly established in OB/GYN for a prenatal patient.

Ancillary Record

Ancillary records consist of original healthcare documentation withheld from a patient's primary HREC or OREC. In certain cases it may be advisable to not file original treatment information in the primary treatment record, but instead place this information into a secondary medical 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 (such as psychiatric treatment or instances of real or suspected child or spouse abuse, etc).

THE MEDICAL RECORD

LEARNING OBJECTIVE: *Recall custody guidelines for medical records.*

All medical records are the property of the U.S. Government and must be maintained by MTFs (naval hospitals, medical clinics, and medical departments of ships, submarines, aviation squadrons, and isolated duty locations) that have primary cognizance over the care of the patient. Medical records are of continuing long-term interest to the government and the patient and must be maintained within an MTF. Patients may not retain original HRECs, ORECs, or dental records. Hand-carrying medical records by unauthorized individuals (e.g., spouses or siblings of the patient) without written permission is prohibited.

HEALTH RECORD CUSTODY

The HREC is retained in the custody of the medical officer on the ship, submarine, or aviation squadron to which the member is assigned. For those ships, submarines, and aviation squadrons that do not have medical officers, the health record may be placed in the custody of the medical department representative (MDR) at the discretion of the commanding officer (CO). Examples of MDRs are Independent Duty Corpsman or Squadron Corpsman. When Medical

Department personnel are not assigned, the CO may assign custody of the health records to the local representatives of the Medical Department who generally furnish medical support. The custody of health record by an individual is not permitted.

Health records are subject to inspection at any time by the commanding officer, superiors in the chain of command, the fleet medical officer, or other authorized inspectors. The health record is for official use only, and adequate security and custodial care are required.

There are many methods of providing adequate security and custodial control of health records. In general, health records should be stored in such a manner as to be inaccessible to the crew or general public. No records or record pages should be left unattended. This precaution also helps to prevent loss or misplacement of records.

Medical Department personnel will maintain a *Health Records Receipt, File Chargeout, and Disposition Record*, NAVMED 6150/7, for each health record in their custody. The completed charge out form should be retained in the file until the record is returned.

Medical officers or MDRs are responsible for the completeness of required health record entries while the record remains in their custody.

CROSS-SERVICING HEALTH RECORDS

The HREC of a Navy or Marine Corps member is normally serviced by personnel of the Medical Department of the Navy. However, if a Navy or Marine Corps member is performing an assignment with the Army or the Air Force, the health record may be serviced by Army or Air Force Medical Department personnel. This management of the health record may be done if the attendant service interposes no objection and considers the procedure feasible. Reciprocal procedures for servicing the health records of Army or Air Force personnel by personnel of the Medical Department of the Navy will be maintained whenever feasible, and if requested by authorized representatives of those services.

DEALING WITH LOST, DESTROYED, OR ILLEGIBLE HEALTH RECORDS

When a HREC is lost or destroyed, the HREC custodian will open a replacement health record. The designation "REPLACEMENT" will be prominently entered on the jacket and all forms replaced. A brief

explanation of the circumstances requiring the replacement and the date accomplished should be entered on SF 600, *Chronological Record of Medical Care*. If the missing record is subsequently recovered, the information or entries in the replacement record will be inserted in the original record.

The HREC or any part of it should be duplicated whenever it becomes illegible or deteriorates to the point that it may endanger its future use or value as a permanent record. The duplicate record or duplicate portion must reproduce as closely to the original as possible. Pay particular attention to detail when you transcribe this information. When you duplicate an entire health record, place the designation "DUPLICATE RECORD" prominently on the front of the jacket above the wording OUTPATIENT MEDICAL RECORD.

When you duplicate only part of the record, identify the individual forms by printing "DUPLICATE" at the bottom of each form. Enter the circumstances necessitating the duplication and the date accomplished on an SF 600. Microfiche all forms replaced for protection and preservation, and make the envelope a permanent part of the medical record. On front of the envelope, record the member's full name, FMP (family member prefix) and SSN, date of birth, and list the original forms contained in the envelope.

If microfilming is not available to the MTF, place the original health forms (except forms contaminated with mold or mildew) inside a plain envelope for preservation and make them part of the permanent record. On the front of the envelope, record the member's identifying data (same as microfiche envelope) and list the contents of the envelope. Mark the envelope "ORIGINAL MEDICAL RECORDS—PERMANENT" and file as the bottommost item in part 2 of the 4-part health record jacket.

DISPOSING OF HEALTH RECORDS DURING HOSPITALIZATION

When a patient is transferred to an MTF, the HREC should accompany the patient. If members are admitted to a military hospital while away from their command, their HRECs should be forwarded as soon as possible to the hospital. If a discharged member is directed to proceed home and await final action on the recommended findings of a physical evaluation board, an entry to this effect should be recorded in the HREC.

If a member is admitted to a civilian hospital for treatment involving brief periods of hospitalization,

the HREC should be retained by the activity until disposition is completed. The HREC will then be forwarded to the cognizant office of medical affairs or to the activity designated by the Commandant of the Marine Corps (CMC) for Marine Corps members. In instances where the parent activity retains the HREC, a summary of the hospitalization will be entered on an SF 600 when the member returns to duty.

When a member is hospitalized at a medical facility of a foreign nation, an entry of this fact should be made in the HREC. The HREC should be retained on board and continued until the patient either returns to duty or is transferred to another U.S. Navy vessel or U.S. military activity. Upon departure of the vessel from the port, the HREC should be delivered to the commanding officer for inclusion in the member's service record for forwarding to the nearest U.S. embassy or consulate.

SECURITY AND SAFEKEEPING OF MEDICAL RECORDS

LEARNING OBJECTIVE: *Recall security and safekeeping procedures for medical records.*

Each MTF or medical department develops policies to ensure that medical records are secure and a patient's privacy is protected. Security and safekeeping are major concerns and responsibilities of staff handling medical records. The medical record contains information that is personal to patients, treated as privileged information, and protected by the **Privacy Act of 1974**. The Privacy Act of 1974 protects a patient's right to privacy in respect to personal medical information. The Privacy Act permits only the patients and their legal representatives to obtain this information.

Medical facilities or departments should take precautions to avoid compromise of medical information during the movement and storage of medical records. Medical records should be handled by only authorized medical service personnel. Records should be stored in a locked area, room, or file to ensure safekeeping, unless there is a 24-hour watch in the records room. Refer to the MANMED for more detailed guidelines on medical record security and safekeeping.

RELEASING MEDICAL INFORMATION

LEARNING OBJECTIVE: *Recognize guidelines for releasing medical information.*

The Surgeon General (also titled Director, Naval Medicine) is the official responsible for administering and supervising the execution of SECNAVINST 5211.5, Department of the Navy Privacy Act Program (PAP), as it pertains to the Health Care Treatment Record System. Additionally, the Office of the Surgeon General authorizes requests for access and amendment to naval members' medical and dental records.

Commanding officers of Navy MTFs are designated as local systems managers for medical records maintained and serviced within their activities. Local systems managers are authorized to release information from health records located within the command if proper credentials have been established. The requesting office or individual will be advised that such information is private and must be treated with confidentiality. In all cases where information is disclosed, an entry must be made on OPNAV Form 5211/9, *Record of Disclosure-Privacy Act of 1974*, and should include the date, nature and purpose of the disclosure, and the name and address of the person or agency receiving the information. Maintain a copy of any such disclosure requests.

GUIDELINES FOR RELEASING MEDICAL INFORMATION

In the following paragraphs, we cover the policy for release of record transcripts. As will be noted, the appropriate rule for release to be implemented depends upon the intended recipient of the record transcript.

1. **Release to the Public.** Information contained in medical records of individuals who have undergone medical or dental examination or treatment is personal to the individual and considered private and privileged in nature. Consequently, disclosure of such information to the public would constitute an unwarranted invasion of personal privacy. Such information is exempt from release under the **Freedom of Information Act**.

However, MTF commanding officers may release some information to the public or the press without the patient's or patient's next of kin's (NOK) consent. This

information is the patient's name; grade or rate; date of admission or disposition; age; sex; component, base, station, or organization; and general condition.

2. **Release to the Individual Concerned.** Release of healthcare information to the individual concerned (patient) falls within the purview of the Privacy Act and not the Freedom of Information Act. When individuals request information from their medical record, it will be released to them unless, in the opinion of the releasing authority, it might prove injurious to their physical or mental health. In such an event, the releasing authority will request authorization from the patients to send their medical information to their personal physician.

3. **Release to Representatives of the Individual Concerned.** Upon the written request from patients, healthcare information will be released to their authorized representatives. If an individual is mentally incompetent, insane, or deceased, the NOK or legal representative must authorize the release in writing. NOK or legal representatives must submit adequate proof that the member or former member has been declared mentally incompetent or insane, or furnish adequate proof of death if such information is not on file. Legal representatives must also provide proof of appointment, such as a certified copy of a court order.

4. **Release to Other Government Departments and Agencies.** When requested, healthcare information will be released to other government departments. These government departments and agencies must have a legitimate need for the information as listed in the "Routine Uses" section of the Medical Treatment Records System, which is annually set forth in SECNAVNOTE 5211, *Systems of Personal Records Authorized for Maintenance Under the Privacy Act of 1974*, 5 USC 552a (PL 93-579).

If the releasing authority is in doubt whether the requesting department has a legitimate need for the information, it will ask the requesting department to specify the purpose for which the information will be used. In some cases, the requesting department should be advised that the information will be withheld until the written consent of the individual concerned is obtained.

RELEASING MEDICAL INFORMATION TO FEDERAL AND STATE AGENCIES

In honoring proper requests, the releasing authority should disclose only information relative to the request. In the following three instances, for

example, departments and agencies, both federal and state, may have a legitimate need for the information:

1. Health care information is required to process a governmental action involving an individual. (The Veterans Administration and the Bureau of Employees' Compensation process claims in which the claimant's medical or dental history is relevant). If an agency requests health care information solely for employment purposes, a written authorization is required from the individual concerned.

2. Health care information is required to treat an individual in the department's custody. (Federal and state hospitals and prisons may need the medical or dental history of their patients and inmates.)

3. Release to federal or state courts or other administrative bodies. The preceding limitations are not intended to prevent compliance with lawful court orders for health records in connection with civil litigation or criminal proceedings, or to prevent release of information from health records when required by law. If you have doubts about the validity of record requests, ask the Judge Advocate General (JAG) for guidance.

RELEASING MEDICAL INFORMATION FOR RESEARCH

Commanding officers of MTFs are authorized to release information from medical records located within the command to members of their staff who are conducting research projects. Where possible, the names of parties should be deleted. Other requests from research groups should be forwarded to Bureau of Medicine and Surgery (BUMED) for guidance.

FILING HEALTH RECORDS

LEARNING OBJECTIVE: *Recall filing procedures for health records.*

The Navy Medical Department uses the Terminal Digit Filing System (TDFS) to file health records. In this system, health records are filed according to the terminal digits (last two numbers) of the service member's social security number (SSN), color coding of the health record jacket, and use of a block filing system.

To understand the TDFS filing system, you will need to view the SSN in a different way. As you know,

the nine digits of the SSN are divided into three number groups for ease in reading. This practice reduces the chance of transposing numbers. For example, in the TDFS system the SSN 123-45-6789 is visually grouped and read from right to left (instead of left to right), as follows:

Primary Group	Secondary Group	Third Group
89	67	123-45

On the health record, the family member prefix (FMP) is added to the patient's social security number. The FMP is a system used by the Navy to show a beneficiary's relationship to the sponsor. For instance, the FMP for active duty personnel is 20, while the FMP for a spouse is 30 (fig. 12-1).

Under the Terminal Digit Filing System, the central files are divided into 100 approximately equal sections. Each section is identified by a maximum of 100 file guides bearing the 100 primary numbers, 00 consecutively through 99. Each of these 100 sections contain records whose terminal digits correspond to the section's **primary number** (fig. 12-1). For example, every record with the SSN ending in 56 is filed in section 56.

Within each of these 100 sections, health records are filed in numerical sequence according to their secondary numbers. The **secondary number** is the pair of digits immediately left of the primary number (fig. 12-1).

To make filing of health records easier, health record jackets are color-coded. The second to the last digit of the SSN is preprinted on the jacket. The color of the health record jacket corresponds to the preprinted digit as follows:

Preprinted Digit	Jacket Color
0	Orange
1	Green
2	Yellow
3	Gray
4	Tan
5	Blue
6	White
7	Almond
8	Pink
9	Red

Centralized files having records based upon more than 200 SSNs, or a file of more than 200 records, may

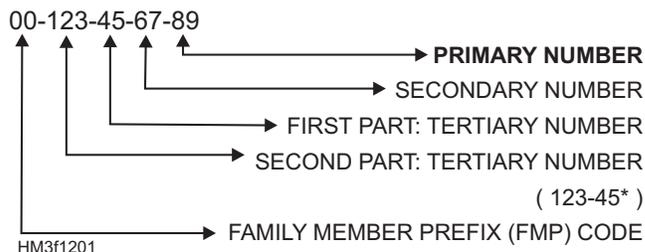


Figure 12-1.—Example of social security number grouping and family member prefix.

need to use the TERTIARY (third) NUMBER in filing. In a properly developed and maintained terminal-digit, color-coded and block-filing system, it is almost impossible to misfile a record. A record misfiled with respect to the left digit of its primary number (for example, a 45 that has been inserted among the 55s) will attract attention because of its different record jacket color. A record jacket misfiled in respect to the right primary number (for example, a 45 that has been inserted among the 42s) causes a break in the diagonal pattern formed by the blocking within a color group.

Authorized exemptions from the requirements of the TDFS are discussed in detail in the MANMED.

OPENING HEALTH RECORDS

LEARNING OBJECTIVE: *Determine when a health record should be opened, and select the appropriate record jacket and sequence of medical forms to be placed within a new record.*

This section will discuss the opening of active duty HRECs. HRECs are opened when an individual becomes a member of the Navy and Marine Corps, when a member on the retired list is returned to active duty, or when the original record has been lost or destroyed.

When establishing the four-part health record, the appropriate military health record jacket and required forms must be current and assembled in accordance with current directives.

OPENING HEALTH RECORDS FOR ACTIVE DUTY OFFICERS

Recruiting offices open HRECs for civilian applicants who are accepted for an officer

appointment. The health record is then forwarded to the new officer's first duty station.

Midshipmen or former enlisted members appointed to commissioned officer or warrant officer grade continue to use their existing HREC. The MTF having custody of the record at the time of acceptance of appointment will make necessary entries to indicate the new grade and the designator or MOS. Also, the record custodian should prepare summary information entries on SF 600 and NAVMED 6150/4 to include date, place, and grade to which the member was appointed.

Health records of civilian candidates selected for appointment to the Naval Academy should be prepared at the Naval Academy at the time of appointment. Health records for civilian applicants selected for officer candidate programs should be opened upon enrollment in the program.

OPENING HEALTH RECORDS FOR ACTIVE DUTY ENLISTED PERSONNEL

The HREC is opened by the activity executing the enlistment contract upon original enlistment in the Navy or Marine Corps. An exception to this rule involves service members who are enlisted or inducted and ordered to immediate active duty at a recruit training facility. In this instance, the HREC will be opened by either the Naval Training Center (NTC) or Marine Corps Recruit Depot, as appropriate. Copies of the service member's SF 88, *Report of Medical Examination*, and SF 93, *Report of Medical History*, are sent to the appropriate NTC or recruit depot, and added to other applicable HREC forms in the member's HREC.

OPENING HEALTH RECORDS FOR RESERVISTS

The Naval Reserve Personnel Center (NRPC), New Orleans, is the HREC custodian for inactive reserve personnel. In addition, NRPC is responsible for the records' preparation and maintenance. When inactive reservists are called to active duty and their HRECs have not been received by their duty station, a request for their records should be initiated. Requests for Navy personnel are sent to NRPC. Marine Corps personnel requests are sent to the **Marine Corps Reserve Support Center**. For Navy and Marine Corps service members who were discharged before 31 January 1994, requests should be sent to the **National Personnel Records Center (NPRC)** for

record retrieval. For service members who were discharged after 31 January 1994, requests for record retrieval are sent to the **Department of Veterans Affairs (DVA)**. Addresses of each of these activities are listed in the MANMED.

PREPARING THE HEALTH RECORD JACKET

A new **military health record jacket**, NAVMED 6150/20-29, should be prepared when an HREC is opened or when the existing jacket has been damaged or is deteriorating to the point of illegibility. The old jacket should be destroyed following replacement.

Preparing the Outside Front Cover and Inside Back Cover

A **felt-tip or indelible black-ink pen** should be used to record all identifying data, except in the "Pencil Entries" block on the upper left of the outer front cover of the HREC. As indicated, information in this block should be written in pencil, so it can be updated or changed. Figure 12-2 illustrates the completed outside front cover and inside back cover of a military health record jacket.

RECORD NUMBERING.—Each health record jacket has the second to the last digit of the SSN preprinted on it. The preprinted digit also matches the last digit of the form number (e.g., the preprinted digit on NAVMED 6150/26 is 6). The color of the treatment record jacket corresponds to the preprinted digit. In preparing a member's treatment record jacket, select a prenumbered NAVMED 6150/20-29 jacket by matching the second to the last number of the member's SSN.

SOCIAL SECURITY NUMBER.—Enter the rest of the member's SSN on the top of the inside back cover. For members who do not have an SSN (e.g., foreign military personnel), use NAVMED 6150/29 as the treatment record jacket. A "substitute" SSN should be created for these members by assigning the numbers "9999" as the last four digits of the SSN and assigning the first five digits in number sequence (e.g., first SSN 000-01-9999, the second SSN 000-02-9999). Place a piece of **black** cellophane tape over the number that corresponds to the last digit of the SSN in each of the two number scales on the inside back cover of the HREC (fig. 12-2).

FAMILY MEMBER PREFIX.—Enter the member's family member prefix (FMP) code in the two diamonds preceding the SSN on the top of the

0 1 2 3 4 5 6 7 8 9

PENCIL ENTRIES

COMMAND TITLE

LAST FIRST MIDDLE
PATIENT IDENTIFICATION (PRINT NAME ABOVE OR AFFIX PREPRINTED LABEL)

Active duty: Specify grade or rate.
Retired Military: Specify preferred form of address; military grade or rate of civilian title.
Civilian: Specify preferred form of address (Mr. Mrs. Ms. Miss, Dr., etc.).

Outpatient Treatment Record
 Dental Treatment Record

Military (provide grade or rate and, if family member, provide sponsor's service and status)
 Navy
 Marine Corps
 Other
 Retired
 Family Member
Family Member Insurance Yes ___ No ___
 Civilian
 Personnel Reliability Program
 Blood Type
 Flight Status
 Food Handler
 Radiation Exposure
 Asbestos Surveillance
 Medical Condition

Instructions
This treatment record is a dual purpose record which may be used as an Outpatient Medical Treatment Record or as a Dental Treatment Record.
1. Place a check in the appropriate box to indicate which type of treatment record you wish this to be.
2. Fill in all appropriate information on the front as well as inside this record.
3. Follow Manual of the Medical Department, chapters 6 (for dental) and 16 (for medical).

Alert
 Allergies
 Sensitivities

BAR CODE LABEL AREA

1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014

0 1 2 3 4 5 6 7 8 9

U.S. Navy Medical Outpatient and Dental Treatment Record
NAVMED 6150/26 (Rev 11-96)
S/N 0105-LF-113-9300

Warning: Property of US Government. Possession by individual without proper authorization is prohibited. Removal of this record or its contents from the treatment facility is prohibited unless authorized by appropriate authority. Postmaster, forward to the nearest US naval medical or dental treatment facility.

HM3F1202

Figure 12-2.—Sample of completed outside front cover and inside back cover of a health record jacket (NAVMED 6150/26.)

inside back cover. Enter the FMP code of 20 for all Navy and Marine Corps members. Enter an FMP code of 00 for all foreign military personnel.

PATIENT'S NAME.—Enter the member's full name (last, first, middle initial, in that order) 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 titles, such as JR, SR, and III, at the end of the name. The name may be handwritten on the line provided or imprinted on a self-adhesive label and attached to the jacket in the patient identification box.

ALERT BOX—In the lower center area of the outside front cover, indicate in the alert box whether the member has drug sensitivities or allergies by entering an "X" in the appropriate box. If there are no allergies or sensitivities, leave it blank.

RECORD CATEGORY.—Indicate the appropriate record category by entering an "X" in the box marked "Health Record" on the outside front cover, just below the "Pencil Entries" block. Then attach ½-inch red tape to the record category block on the right edge of the inside back cover of the jacket; this indicates it's an active duty record.

PATIENT SERVICE AND STATUS.—Below the record category box is the patient service and status box. Mark an "X" in the appropriate service block.

SPECIAL CATEGORIES OF RECORDS.—Identify the records of personnel assigned to special duty or medical surveillance programs (e.g., personnel reliability program, flight status, or the Asbestos Medical Surveillance Program) by marking an "X" at the appropriate special category entry listed below the record category type.

Identify flag officers and general officers by stamping or printing "FLAG OFFICER" or

“GENERAL OFFICER,” as appropriate, on the lower portion of the patient identification box. If a patient identification label is used, print or stamp the appropriate identification below the label.

PENCIL ENTRIES.—Following the instructions on the front cover, pencil in the appropriate title (i.e., grade or rate, if on active duty; preferred form of address, if retired or civilian), and include the current command (if active duty).

RECORD RETIREMENT TAPE BOX.—Leave the record retirement tape box on the inside back cover blank.

BAR CODE.—Some Navy medical facilities have bar coding capabilities. The bar code label indicates the patient’s FMP, SSN, record type, and record volume number. Affix the label to the front of the record jacket in the box right of the alert box. If the bar code is part of the patient identification label (such as the patient identification label produced by the Composite Health Care System (CHCS) computers), place this label in the patient identification box.

LABELS.—Use of a self-adhesive label with the name of the MTF, ship, or other units having custodial responsibility for the record is optional. Ship or MTF logos are permitted as long as the necessary patient identifying information is not obscured. For further details see the appropriate MANMED article covering this subject.

Preparing the Inside Front Cover

Enter the following information in pencil on the inside front cover of the HREC jacket. Record the information in the inside of the front cover in pencil to permit changes and updating.

- Date of arrival
- Projected departure date
- Home address and telephone number
- Duty station and telephone number

Preparing the Middle Section

The middle section of the HREC contains a preprinted DD 2005, *Privacy Act Statement—Health Care Records*, on the front side. When opening an HREC, the service members are asked to read the Privacy Act Statement. After the members have read the statement, they will need to sign, date, and include their SSN at the bottom of the form. Signing this

statement indicates the service members understand their right to confidentiality in regard to the medical documentation placed in their HREC.

On the reverse of the middle section is a Disclosure Accounting Record. This form should be annotated whenever the HREC is released to any individual or agency outside the MTF.

SEQUENCE OF HEALTH RECORD FORMS

When assembling an HREC, you should arrange the forms in chronological order by date. The most current document should be placed on top, and the least current documents below it. The HREC contains dividers that partition the record into four parts. A sequential listing of medical forms to be filed in each section is provided in table 12-1. The titles for each part of the HREC are as follows:

- Part 1. Record of Preventive Medicine and Occupational Health
- Part 2. Record of Medical Care and Treatment
- Part 3. Physical Qualifications
- Part 4. Record of Ancillary Studies, Inpatient Care, and Miscellaneous Forms

HEALTH RECORD FORMS

LEARNING OBJECTIVE: *Recall the purpose and completion procedures for the health record forms discussed in this section.*

In the last section, you learned there are many medical forms placed in the health record. Also, you learned each form has a specific location within the record. The methods for the management of major areas of health care, both ashore and afloat, are rapidly changing. The Composite Health Care System (CHCS), a secure, computer-based system, is now the primary means that healthcare practitioners use to schedule and process patient visits, track medical results, order labs and x-rays, and process orders for medications. CHCS is especially valuable for pier-side healthcare providers and furnishes a much higher standard for patient care.

Computerized medical documentation (e.g., laboratory test results, emergency room reports, etc.)

Table 12-1.—Sequential List of Health Record Forms

LEFT SIDE OF HREC FOLDER (Top to bottom with most current entry on top within group of forms)	RIGHT SIDE OF HREC FOLDER (Top to bottom with most current entry on top within group of forms)
<p>Left Side - Part 1: Record of Preventive Medicine & Occupational Health</p> <p>NAVMED 6150/20, Summary of Care Form <i>[Always on top.]</i> SF 601, Immunization Record NAVMED 6000/2, Chronological Record of HIV Testing DD 771, Eyewear Prescription NAVMED 6490/1, Visual Record NAVMED 6470/10, Record of Occupational Exposure to Ionizing Radiation NAVMED 6470/11, Record of Exposure to Ionizing Radiation from Internally Deposited Radionuclides <i>[Interfile behind 6470/10 with corresponding dosimetry issue period.]</i> DD 2215, Reference Audiogram DD 2216, Hearing Conservation Data NAVMED 6224/1, TB Contact/Converter Follow-up NAVMED 6260/5, Asbestos Medical Surveillance Program DD 2493-1, Asbestos Exposure-Part I, Initial Medical Questionnaire <i>[Attach to correspondence NAVMED 6260/5.]</i> DD 2493-2, Asbestos Exposure-Part II, Periodic Medical Questionnaire OPNAV 5100/15, Medical Surveillance Questionnaire Other 5100 Forms—Occupational Health Series Forms</p>	<p>Left Side - Part 3: Physical Qualifications, Administrative Forms</p> <p>NAVMED 1300/1, Medical & Dental Overseas Screening Review for Active Duty & Dependents NAVPERS 1300/16, Report of Suitability for Overseas Assignment - Parts I, II, and III NAVMED 6100/1, Medical Board Report Cover Sheet NAVMED 6100/2, Medical Board Statement of Patient NAVMED 6100/3, Medical Board Certificate NAVMED 6100/5, Abbreviated Temporary Limited Duty DD 2569, Third Party Collection Program <i>[See BUMEDINST 7000.7 series for additional guidance.]</i> SF 2824C, Physicians Statement for Employee Disability Retirement SF 47, Physical Fitness Inquiry For Motor Vehicle Operators SF 78, Certificate of Medical Examination DD 2005, Privacy Act Statement</p>
<p>Right Side - Part 2, Section A: Record of Medical Care and Treatment</p> <p>NAVPERS 5510/1, Record Identifier for personnel Reliability Program (PRP) <i>[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.]</i> SF 558, Medical Record Emergency Care and Treatment Record of Ambulance Care SF 600 HREC—Chronological Record of Medical Care <i>[If for outpatient surgery, dictate or document immediately after surgery and file with corresponding SF 516. Otherwise file as exhibited here.]</i> SF 513, Medical Record Consultation Sheet DD 2161, Referral For Civilian Medical Care</p>	<p>Right Side, Part 4, Record of Ancillary Studies, Therapies, etc.</p> <p>SF 217, Medical Report-Epilepsy SF 88, Report of Medical Examination SF 93, Report of Medical History <i>[File behind corresponding SF 88 or SF 78.]</i> BUMED Waiver Letters with BUPERS Endorsement NAVMED 6120/1, Competence for Duty Examination NAVMED 6120/2, Officer Physical Examination Special Questionnaire <i>[File in place of SF 93 when used.]</i> NAVMED 6120/3, Annual Certificate of Physical Condition NAVMED 6150/2, Special Duty Medical Abstract NAVMED 6150/4, Abstract of Service and Medical History NAVJAG 5800/10, Injury Report NAVJAG Report - Investigation to inquire into the circumstances surrounding the injury of (servicemember). NAVPERS 1754/1, Exceptional Family Member (EFM) Program Application Living Will or Medical Power of Attorney OPNAV 5211/9, Record of Disclosure, Privacy Act of 1974 DD 877, Request for Medical/Dental Records SF 515, Medical Record Tissue Examination SF 519A, Radiographic Consultation Request/Report SF 519B, Medical Record-Radiologic Consultation Request/Report SF 519, Medical Record-Radiographic SF 518, Medical Record-Blood or Blood Component Transfusion SF 520, Medical Record-Electrocardiogram Request SF 524, Radiation Therapy SF 525, Radiation Therapy Summary SF 526, Medical Record-Interstitial/Intercavity Therapy SF 527, Group Muscle Strength, Join ROM, Girth and Length Measurements SF 528, Medical Record-Muscle Function By Nerve Distribution: Face, Neck and Upper Extremity SF 529, Medical Record-Muscle Function by Nerve Distribution: Trunk and Lower Extremity SF 530, Neurological Examination SF 531, Anatomical Figure <i>[May also be filed under a corresponding SF 600, SF 513, etc.]</i> SF 541, Medical Record Gynecologic Cytology SF 545, Laboratory Report Display SF 546 - 557, Laboratory Reports. <i>[Attach through to SF 545 in chronological order.]</i> SF 559, Medical Record-Allergen Extract Prescription New and Refill SF 560, Medical Record-Electroencephalogram Request and History SF 511, Vital Signs Record SF 512, Plotting Chart SF 512A, Plotting Chart Blood Pressure</p>
<p>Top Forms in Part 2, Section A When a Patient is Deceased</p> <p>Attestation Sheet DD 2064, Certificate of Death SF 503, Autopsy Protocol SF 523, Authorization for Autopsy SF 523A, Disposition of Body SF 523B, Authorization For Tissue Donation</p>	
<p>Right Side - Part 2, Section B: Inpatient Care, Ambulatory Surgeries, etc.</p> <p>NAVMED 6300/5, Inpatient Admission/Disposition Record (Copy) SF 502, Medical Record, Narrative Summary (Copy) SF 539, Medical Record-Abbreviated Medical Record (Copy) SF 509, Progress Notes SF 516 Medical Record-Operation Report (Original for Outpatient Surgery) <i>[Dictate/document immediately after surgery.]</i> SF 600 HREC—Chronological Record of Medical Care <i>[Outpatient Surgery: To be dictated immediately after surgery] [File with corresponding SF 516.]</i> SF 517, Anesthesia SF 522, Request for Administration of Anesthesia <i>[File with corresponding SF 517.]</i> SF 533 Medical Record-Prenatal and Pregnancy (Only for patients not admitted for delivery) Civilian Medical Care Notes DD 602, Patient Evacuation Tag <i>[Staple to current SF 600.]</i></p>	

HM3t1201

has become commonplace. However, the Navy Medical Department continues to use many government printed forms (e.g., NAVMED, DD, and SF). This section will cover selected (government-printed) medical forms, their purpose, and procedures for completing them.

Healthcare providers should enter their signature and identification data in the HREC in black or blue-black ink. Type, print, or stamp provider's name, grade or rating, and social security number below their signature. Stamped facsimile signatures are NOT to be used on any medical form in the HREC. The signing individual assumes responsibility for the correctness of the entry for which they sign.

All medical forms require an accurate and complete documentation of patient identification data. Patient identification data on medical documentation is critical. Complete and accurate documentation of patient identification data helps to ensure the documents are placed in the correct patient's record. Three methods are currently used to place patient identification on medical documents:

- embossed medical card,
- automated forms, and
- handwritten entries.

Embossed medical cards are used to imprint patient identification data on medical forms. Printouts of automated (computerized) forms should provide the information listed in table 12-1. Handwritten patient identification data should be entered in spaces at the bottom of the form. Each method should contain, at a minimum, the patient identification data listed in table 12-2.

SUMMARY OF CARE (NAVMED 6150/20)

The Summary of Care (fig. 12-3) contains a summation of relevant problems and medications that significantly affect the patient's health status. Properly maintained, the Summary of Care form aids healthcare providers by allowing them quick access to pertinent medical factors that may affect how they manage a patient's medical care. This form is a permanent part of the HREC.

Entries on the NAVMED 6150/20 should include significant medical and surgical conditions, allergies, untoward reactions to medication, and medications currently using or recently used. The Summary of Care form should be reviewed, and, if necessary,

Table 12-2.—Patient Identification Data

Item #	Patient Identification Data
1	Full name (last, first, middle)
2	FMP + SSN
3	Date of birth (YY-MM-DD)
4	Sex of patient (M or F)
5	Sponsor (self)
6	Sponsor's Agency or military service (USN, USMC, USCG,...)
7	Patient's paygrade (e.g., E7, O2)
8	MTF maintaining record (e.g., NH Pensacola, etc.)

revised during the patient's visit. The NAVMED 6150/20 should also be reviewed during yearly verification and before HREC transfers.

The Summary of Care form is divided into five sections: significant health problems, hospitalization/surgery, medical alert, medications, and health maintenance.

- **Significant health problems section:** Enter only significant medical conditions in this section. Significant medical conditions include chronic diseases (such as hypertension, diabetes, arthritis, etc.) and acute recurrent illnesses (such as recurrent urinary tract infections, recurrent otitis media, recurrent bronchitis, etc.)

- **Hospitalization/surgery section:** Enter significant surgical conditions. Include all procedures requiring general or regional anesthesia and any procedures likely to have a long-term effect on the patient's health status.

- **Medical alert section:** Note any allergies and significant reactions to drugs in the medical alert section. Record also in this section relevant alcohol and tobacco use.

- **Medications section:** Record all currently or recently used medications.

- **Medical maintenance section:** This section of the NAVMED 6150/20 contains a variety of medical information. It contains health maintenance functions, such as mammograms, chest X-rays, EKGs, and pap smears. Enter the date of the health maintenance functions in pencil, so it can be updated. Include in this section occupational health surveillance activities, such

File as top page on left side of folder

Summary of Care

(This form is subject to the Privacy Act of 1974)

No.	Significant Health Problem	Date	Medical Alert <i>(SBE Prophylaxis, allergies, other)</i>		
1.	Right Thyroid Nodule	19Aug95	Aspirin		
2.	Influenza	30Jan97			
3.	Urinary Tract Infecton	16Nov99			
4.					
5.			Alcohol:		
6.			Tobacco:		
7.			Medications	Start	Stop
8.			Tylenol (PRN)	30Jan97	
9.			Ciprofloxacin 250mg BID	16Nov99	25Nov99
10.			Pyridium 200mg TID	16Nov99	18Nov99
11.					
	Exceptional Family Member Program				
	Hospitalization/Surgery	Date	Health Maintenance	Date of Last Test <i>(Pencil entry)</i>	
1.	Tonsillectomy	1974	Prostate Exam	N/A	
2.	Wisdom Teeth extracted X 4	23Mar96	RPR	06 Feb 98	
3.			G6PD / GPAB	06 Feb 98	
4.			Stool GUAIC	06 Feb 98	
5.			Mammogram		
6.			Chest X-Ray		
7.			ECG	06 Feb 98	
8.			Birth Control Method		
9.			PAP Smear	06 Feb 98	
10.	Advance Directive Provided:		Sickle Cell Trait	06 Feb 98	
11.	Advance Directive Returned:		HIV Screen	06 Feb 98	
12.			Other		

(Continue significant health problems, medications, hospitalization/surgery on reverse)

Space for Mechanical Imprint	Patient's Name:	Rank/Grade:	Sex:
	Frost, Jane O.	HMCS	Female
	SSN/Identification Number:	Status:	Date of Birth:
	20-123-45-6789	Active Duty	02Dec69
Branch of Service:	Organization:		
	USS Reliable		
Sponsor's Name:	Relationship to Sponsor:	Records maintained at:	
SSA	Self	USS Reliable	

NAVMED 6150/20 (Rev. 1-94)
S/N 0105-LF-017-9000

Fold along line. File on left side of folder.

Figure 12-3.—Summary of Care, NAVMED 6150/20.

as involvement in the Asbestos Program, the Hearing Conservation Program, or exposure to lead. Include also the following laboratory tests: blood type, G6PD, and sickle trait.

CHRONOLOGICAL RECORD OF MEDICAL CARE (SF 600)

The *Chronological Record of Medical Care*, SF 600, provides a current, concise, and comprehensive record of a member's military medical history (fig. 12-4, view A and B). Use the SF 600 for all outpatient care and file in the HREC. Record all visits, including those that result in referrals to other MTFs, on the SF 600. Each person making an entry on the form must sign the entry and include his identification information (full name, grade or rate, profession [e.g., MC, NC, etc.], and SSN), either hand printed, typed, or stamped.

Properly maintained, the SF 600 facilitates the evaluation of a patient's physical condition and reduces correspondence necessary to obtain medical records. Appropriate use of the form also eliminates unnecessary repetition of expensive diagnostic procedures and serves as an invaluable permanent record of medical evaluations and treatments.

Completing the SF 600

Entries made on the SF 600 can be typewritten when practical. However, entries normally are handwritten with black or blue-black ink pens. When initiating an SF 600, patient identification data should be completed. Also, type or stamp the date (DD-MMM-YY) and the name and address of the activity responsible for the entry.

Use both sides of each SF 600. 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 the 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 needs to be crossed out and the words "This side not used," printed in the middle of the form.

SF 600s are continuous and include the following information: complaints, duration of illness or injury, physical findings, clinical course, results of laboratory or other special examinations, treatment (including operations), physical fitness at the time of disposition, and disposition. The subjective complaint, observation, assessment, and plan (SOAP) format may be used for entries so long as the required information in table 12-3 is included.

Table 12-3.—Required Information on an SF 600

ITEM	REMARKS
Date	A complete date must be included with every entry in the HREC. 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 Apr 96).
MTF name	Name of hospital, clinic, or ship
Clinical department or service	(e.g., Military Sick Call, Orthopedic Department., etc.)
Chief complaint or purpose of visit	(e.g., headache, PRT screening, etc.)
Objective findings	
Diagnosis or medical impression	
Studies ordered and results	(e.g., laboratory, X-ray, etc.)
Therapies administered	
Patient disposition, recommendations, and patient instructions	(e.g., SIQ for 24 hours, referral to specialty clinic, etc.)
Healthcare provider's name and signature	Include the provider's grade or rate, profession (e.g., MC, NC), and SSN

Enter the following information indicated on table 12-3 on the patient's SF 600.

Record each visit and the complaint described, even if a member is returned to duty without treatment. Also, document if a patient leaves before being seen.

Other SF 600 Entries

Other SF 600 entries include the following:

- Imminent hospitalization
- Special procedures and therapy
- Sick call visit

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (<i>Sign each entry</i>)	
1 DEC 97	NAVAL HOSPITAL, BLANK, VA Member cut forehead when he slipped in shower and struck head on edge of shower stall. 1" (2.54 cm) laceration over left eyebrow. Wound cleaned and sutured with six 6-0 nylon sutures. Tetanus Toxoid booster given. To duty. To return to sick call on 6 Dec 97.	
	<i>W. T. Door</i> W. T. DOOR 111-11-1111 LCDR, MC, USNR	
6 Dec 97	NAVAL HOSPITAL, BLANK, VA Forehead laceration healing well. Sutures removed. No other complaints. To duty.	
	<i>W. T. Door</i> W. T. DOOR 111-11-1111 LCDR, MC, USNR	
10 Jan 98	NAVAL HOSPITAL, BLANK, VA Health and Dental records screened. Physically qualified for transfer.	
	<i>Jack R. Frost</i> HM1 J. R. FROST, USN 222-22-2222	
23 Feb 98	USS CARRIER (CV-00) Transcribed from DD 689 - NAS Dispensary, Blank, VA, dated 21 Feb 98	

PATIENT'S IDENTIFICATION (<i>Use this space for Mechanical Imprint</i>)		RECORDS MAINTAINED AT:  Naval Hospital, Blank, VA
PATIENT'S NAME (<i>Last, First, Middle initial</i>) DOE, John R.		SEX M
RELATIONSHIP TO SPONSOR N/A	STATUS AD	RANK/GRADE HM3
SPONSOR'S NAME N/A		ORGANIZATION Fighter Sq.-VF 143
DEPART./SERVICE USN	SSN/IDENTIFICATION 20-123-45-6789	DATE OF BIRTH 9 May 75

CHRONOLOGICAL RECORD OF MEDICAL CARE STANDARD FORM 600 (REV. 5-84)
 Prescribed by GSA and ICMR
 FIRM (41 CFR) 201-45-45.505

Figure 12-4.—Chronological Record of Medical Care, SF 600: A. Front view.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (<i>Sign each entry</i>)	
5 Mar 98	"Member injured right hand when he struck hand on backboard during COMNAVAIRLANT basketball game at 2030 this date. X-ray of right hand negative for fracture or dislocation. Impression: Contusion rt. hand. Treatment: Hot soaks for next several days and ASA 10 gr q4h prn for pain. To duty. /s/CDR P. T. BOATE, MC,USNR"	<i>A. B. Seaman</i> HM2 A. B. SEAMAN, USN 333-33-3333
19 Mar 98	USS CARRIER (CV-00) DIAGNOSIS: Contusion, left thoracic region. ICDA Code No. 9220 Line of duty. Not due to own misconduct. While descending hatchway, slipped and fell, striking left chest against hatch combing. Patient complains of shortness of breath with pain and discomfort in left thoracic region. Examination indicates possibility of internal injuries, and as this ship is leaving port tomorrow on extended operation, it is deemed medically advisable to transfer this patient to a hospital.	
19 Mar 98	Transferred to Naval Hospital, Blank, VA	<i>A. B. Smith</i> A. B. SMITH, LT, MC, USN 444-44-4444
	APPROVED: <i>J. R. Frost</i> J. R. Frost CAPT, MC, USN 555-55-5555	
19 Mar 98	NAVAL HOSPITAL, BLANK, VA DIAGNOSIS: Contusion, left thoracic region. ICDA Code No. 9220 Line of duty. Not due to own misconduct. Admitted from USS CARRIER (CV-00) where while descending hatchway, patient slipped and fell, striking left chest against hatch combing. Complains of shortness of breath and severe pain in area of 4th thoracic rib. X-RAY: Examination of entire right and left thoracic regions reveals no evidence of fracture or bone pathology. TREATMENT: Heat application and bed rest. Slight pain with motion. Discomfort subsiding. On 24 Mar 98, patient developed acute sore throat. Temp. 101.2 (38.7); pharynx injected, tonsils inflamed. Exudate cultured.	
	DIAGNOSIS CHANGED on 26 Mar 98 by reason of intercurrent diagnosis. Tonsillitis, Acute, Streptococcal, ICDA Code No. 4630 Line of duty. Not due to own misconduct. Placed on antibiotic therapy. (Penicillin) On 1 May 98, Temp. 98.6 (37.3); all medication discontinued. Slight discomfort and tenderness remain in left thoracic region. Ward privileges authorized.	
4 May 98	No complaints. To duty. Well.	<i>V.C. Pistol</i> V. C. PISTOL, LT, MC, USN 666-66-6666
	APPROVED: <i>M. N. Chairman</i> M. N. CHAIRMAN Chief Service CAPT, MC, USN 777-77-7777	

*U.S.GPO: 1997-426-840/69077

STANDARD FORM 600 BACK (REV. 5-84)

HM3F1204B

Figure 12-4.—Chronological Record of Medical Care, SF 600: B. Back view.

- Injuries or poisonings
- Line-of-duty inquiries
- Binnacle list and sick list
- Reservist check-in and check-out statements

IMMINENT HOSPITALIZATION.—When an admission of a patient is imminent, admission notes can be made on an SF 600. However, the use of the SF 509, *Medical Record-Progress Report*, is preferred. The SF 509 form is routinely used for inpatient admission notes and are filed in the patient’s IREC. Record referred or postponed inpatient admissions on the SF 600.

SPECIAL PROCEDURES AND THERAPY.—When patients are seen repeatedly for special procedures or therapy, such as physical and occupational therapy, renal dialysis, or radiation, note the therapy on the SF 600 and record interim progress statements. Initial notes, interim progress notes, and any summaries may be recorded on any appropriate authorized form, but should be referenced on SF 600. Write a final summary when special procedures or therapy are ended. This summary should include the result of evaluative procedures, the treatment given, the reaction to treatment, the progress noted, condition on discharge (when applicable), and any other pertinent observations.

SICK CALL VISITS.—Whenever a member is evaluated at sick call, an entry will be made on an SF 600 reflecting the complaints or conditions presented, pertinent history, treatment rendered, and disposition.

INJURY OR POISONING.—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, *Inpatient Data System*.

LINE-OF-DUTY INQUIRIES.—When a member of the naval service incurs an injury that might result in permanent disability or results in his physical inability to perform duty for a period exceeding 24 hours, an entry should be made concerning line-of-duty misconduct. Such entries should include facts, such as time of injury, date, place, names of persons involved, and the circumstances surrounding the injury.

A line-of-duty inquiry is conducted to establish whether the injuries the patient sustained are the result of misconduct on the part of the member or others. For more details on line-of-duty inquiries, see the *Manual of the Judge Advocate General (JAGMAN)*.

BINNACLE LIST AND SICK LIST.—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.

When an active duty member is placed on the Sick List, the medical department representative (MDR) should 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.

SERIOUSLY ILL/VERY SERIOUSLY ILL (SI/VSI) LIST.—Place personnel whose illness or injuries are severe on the SI/VSI List (as defined in MILPERSMAN 4210100) and make appropriate notification.

RESERVIST CHECK-IN AND CHECK-OUT STATEMENTS.—Naval Reserve personnel who are checking in, or out on orders for annual training (AT), active duty for training (ADT), or inactive duty training travel (IDTT) should sign the following statements. The statements should be entered on an SF 600 and signed by the reserve member and the MDR.

For personnel checking in:

I certify that 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.

(Member’s and MDR’s signature and date)

For personnel checking out:

I certify that I have/have not incurred or aggravated any injuries or illnesses during the period of Naval Reserve service.

(Member’s and MDR’s signature and date)

Special SF 600s

Two special SF 600s will be covered in the section. Both forms perform specific functions.

SPECIAL-HYPERSENSITIVITY SF 600.—Indicate any hypersensitivity to drugs or chemicals on a separate SF 600 (fig. 12-5). The SF 600 will be marked “SPECIAL-HYPERSENSITIVITY” at the

NSN 7540-00-634-178	
HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (<i>Sign each entry</i>)
RETAIN IN PERMANENT HEALTH RECORD	
6 Jun 97	Determined to be hypersensitive to ASPIRIN
8 Nov 97	Determined to be hypersensitive to INFLUENZA, POLY VALENT VACCINE
21 Nov 97	Determined to be hypersensitive to EGGS
"SPECIAL HYPERSENSITIVITY"	
PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)	RECORDS MAINTAINED AT: Naval Hospital, Blank, VA
	PATIENT'S NAME (Last, First, Middle initial): SEAMAN, Able B. SEX: Male
	RELATIONSHIP TO SPONSOR: Self STATUS: AD RANK/GRADE: BM3
	SPONSOR'S NAME: N/A ORGANIZATION: USS CARRIER
	DEPART./SERVICE: USN SSN/IDENTIFICATION: 20-123-45-6789 DATE OF BIRTH: 15 May 75
	CHRONOLOGICAL RECORD OF MEDICAL CARE STANDARD FORM 600 (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45-45.505

HM3f1205

Figure 12-5.—Standard Form 600, Special-Hypersensitivity.

bottom of the page. Appropriate entries regarding the hypersensitivity should be made on the SF 601 (Immunization Record), SF 603 (Dental Report), NAVMED 6150/10-19 (HREC jacket), and the NAVMED 6150/20 (Summary of Care).

BLOOD GROUPING AND TYPING RECORD.—The Blood Grouping and Typing Record, which is generated at the member's initial entry processing point, is an SF 600 overprint. Information on the Blood Grouping and Typing Record identifies the individual by the appropriate ABO group and Rh type (positive or negative). Testing results are documented on the form and the original laboratory request filed with the SF 545, *Laboratory Result Display*, in the member's HREC. The Blood Grouping and Typing Record may also contain a syphilis screening test and other screening test for the presence of certain diseases.

IMMUNIZATION RECORD (SF 601)

The purpose of the SF 601 form (fig. 12-6) is to record prophylactic (disease preventive) immunizations; sensitivity tests; reactions to transfusions, drugs,

sera (*sing.* serum), and food; known allergies; and blood-typing. The SF 601 contains specified blocks for various immunizations, such as yellow fever vaccine, typhoid vaccine, and influenza vaccine.

Preparing and Maintaining SF 601

An immunization record is prepared and maintained for each person with an HREC. Information on the SF 601 is recorded in designated blocks. When space is exhausted in any single category, prepare a new SF 601 and file in the HREC in chronological order. 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 because of a change in grade, rating, name, or status of member. Never maintain the SF 601 separate from the HREC. Information recorded on the SF 601 is normally needed for government international travel, such as unit deployments or directed governmental travel.

Immunization Entries

The name of the medical officer or MDR administering the immunization or test or determining

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX (Number of previous vaccination scars)

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1	05Jan98	Nat'l Drug Company	Y101	Naval Base, Norfolk, VA	J. B. Doe
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	07Jun95	Vi 0.5/ Q 2 yrs	A. B. Smith	4			
2	23Jul97	4 caps/ Q 5 yrs	W. T. Door	5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	05Jan98	0.5 cc	J. B. Doe	4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1	12Jan98	J. B. Doe	4			7		
2			5			8		
3			6			9		

PATIENT'S IDENTIFICATION (Mechanically Imprint, Type of Print):

SEAMAN, Able B.
Male 09May75
YN2 N/AD
20-123-45-6789

◀ Patient's Name— last, first, middle initial;
Sex; Age or Year of Birth; Relationship to Sponsor;
Component/Status; Department/Service.
◀ Sponsor's Name— last, first, middle initial;
Rank/Grade; SSN or Identification Number;
Organization.

601-105

IMMUNIZATION RECORD
Standard Form 601 October 1975 (Rev)
General Services Administration & Interagency
Committee on Medical Records
FPMR (41 CFR) 201-45.505

HM3F1206A

Figure 12-6.—Immunization Record, SF 601: A. Front view.

ORAL POLIOVIRUS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	05Jun00	0.5cc	J. R. Frost	3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
3	15Nov96	0.5cc	A. B. Smith	3	01Nov98	0.5cc	J. B. Doe
4	15Oct97	0.5cc	W. T. Door	4	20Oct99	0.5cc	J. R. Frost

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1	27Aug99	MMR		J. R. Frost	5	06Jun00	HepatitisA#2	1.0cc	J. R. Frost
2	16Nov99	Varicella #1	0.5cc	J. R. Frost	6				
3	16Dec99	Varicella #2	0.5cc	J. R. Frost	7				
4	23Dec99	HepatitisA#1	0.1cc	J. R. Frost	8				

SENSITIVITY TEST (*Tuberculin, etc.*)

	DATE	TYPE	DOSE	ROUTE	RESULT	PHYSICIAN'S NAME
1	16Nov98	TB (Mantoux)	0.1cc	Intradermal	zero mm	J. B. Doe
2						
3						
4						
5						

REMARKS:

(1) HYPERSENSITIVITY TO ASPIRIN

(2) HISTORY MODERATELY SEVERE REACTION TO PARENTERAL PENICILLIN IN 1995

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO. 2.

Figure 12-6.—Immunization Record, SF 601: B. Back view.

the nature of the sensitivity reaction should be typed or stamped on the SF 601 form. Signatures are not required; however, when signatures are used, make sure you can read them.

The medical officer or Medical Department representative administering the immunization is responsible for completing entries in the appropriate sections of SF 601. For smallpox (if administered), cholera, yellow fever and anthrax immunizations, record the manufacturer's name and batch or lot number.

NOTE: The specific protocol for recording anthrax immunizations is outlined in SECNAVINST 6230.4.

Type any hypersensitivity to drugs or chemicals under "Remarks and Recommendations" in capital letters (e.g., "HYPERSENSITIVITY TO ASPIRIN," "HYPERSENSITIVE TO LIDOCAINE"). This entry is in addition to a similar entry required on the SF 603, the SF 600 Special-Hypersensitivity form, and the NAVMED 6150/20 retained permanently in the HREC.

When recording positive results (10 mm or more induration) of the tuberculin skin test (PPD), refer to the *Tuberculosis Control Program* instruction, BUMEDINST 6224.8, for guidance.

Disposing of SF 601

When a service member is released from active duty or separated from the service, the SF 601 is to remain with the HREC.

INTERNATIONAL CERTIFICATES OF VACCINATION (PHS-731)

All personnel performing international travel should be immunized in accordance with NAVMEDCOMINST 6230.15, *Immunizations and Chemoprophylaxis*, and the current edition of FM 8-33/NAVMED P-5038, *Control of Communicable Diseases of Man*. Service members should have a properly completed and authenticated PHS-731 form (International Certificates of Vaccination) in their possession. The PHS-731 form is issued to service members for independent international travel. This form, kept by the individual, is a personal record of immunizations. The PHS-731 is not to be filed in the HREC at any time. Any immunizations recorded on the PHS-731 should be transcribed onto the SF 601.

According to international rules, entries on the PHS-731 require authentication for immunizations against smallpox (if administered), yellow fever, cholera, and anthrax. Authentication (proof the immunization has been given) is accomplished by stamping each entry with the Department of Defense (DoD) immunization stamp and by the healthcare provider's signature. The signature block may be stamped or typewritten and authenticated with the healthcare provider's signature.

ABSTRACT OF SERVICE AND MEDICAL HISTORY (NAVMED 6150/4)

This form provides a chronological history of the ships and stations to which a member has been assigned for duty and treatment, and an abstract of medical history for each admission to the Sick List.

A NAVMED 6150/4 (fig. 12-7) is prepared upon opening the health record, and it remains with the health record regardless of any change in the member's status. Continuation sheets are incorporated whenever a current abstract is completely filled. Complete columns of the NAVMED 6150/4 as follows:

- **Ship or Station column.** Enter the name of the ship or command to which the member is attached for duty or treatment.
- **Diagnosis, Diagnosis Number, and Remarks column.** Enter the diagnosis title and International Classification of Diseases (ICDA) number each time final disposition from the Sick List is made. When there is more than one diagnosis for a single admission, record each diagnosis.
- **Date column.** Indicate in the "From" and "To" subcolumns all dates of reporting and detachment for duty or dates of admission and discharge from the Sick List. Upon transfer for temporary duty (TDY), make an entry only if the HREC accompanies the individual to the place of TDY.

NAVMED 6150/4 is retained as a permanent part of the HREC. When the record is closed, make an entry indicating the date, title of servicing activity, and explanatory circumstances.

Upon discharge and immediate reenlistment, or change in status, an appropriate entry to this effect should be made on the current NAVMED 6150/4. Subsequent chronological entries are continued on the same form.

the *Radiation Health Protection Manual*, NAVMED P-5055.

ADJUNCT HEALTH RECORD FORMS AND REPORTS

This section provides instruction for using certain forms in the health record instead of transcribing their data to the SF 600, *Chronological Record of Medical Care*.

Narrative Summary (SF 502)

The purpose of the SF 502 is to summarize clinical data relative to treatment received during periods of hospitalization. The narrative summary should include all procedures and diagnoses, and must agree with information listed on the *Inpatient Admission/Disposition Report* (NAVMED 6300/5) and any information listed in the operation report.

The SF 502 should include the following information:

- Reason for hospitalization, including a brief clinical statement of the chief complaint and history of the present illness.
- All significant findings.
- All procedures performed and treatment given, including patient's response, complications, and consultations.
- The condition and relevant diagnosis at the time of patient's transfer or discharge.
- Discharge instructions given to patients or their families (i.e., physical activity permitted, medication, diet, and follow-up care).
- List of principal providers or attending physicians and their signatures.

A completed copy of the SF 502 should accompany patients who are transferred to another medical facility. Upon discharge from the hospital, a copy of the SF 502 should be taken to the member's parent command. The SF 502 informs the command of any limitations, medications, and follow-up care the service member may need. After command use, the SF 502 should be placed into the member's HREC. For more detailed instruction on the use of the SF 502, refer to the MANMED.

Abbreviated Clinical Record (SF 539)

The SF 539 may be used as a substitute for the narrative summary for those admissions of a minor nature that require less than 48 hours of hospitalization. A copy of SF 539 should be filed in the HREC.

Consultation Sheet (SF 513)

The SF 513 is used for outpatients who need to be referred to other healthcare providers or specialists, such as gynecologists, internists, optometrists, etc. The primary patient assessment should be entered onto the form. Include as well the results of examinations and tests on the SF 513. 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 original consultation form stays in the HREC.

Medical Board Report (NAVMED 6100/1)

Whenever a member of the naval service is reported on by a medical board, place a legible copy of the report in the health record instead of transcribing the clinical data to the SF 600. Make a notation on the current SF 600 to indicate the clinical data is contained in the copy of the Medical Board Report incorporated in the health record, when the Medical Board Report is forwarded to the Navy Department for review and appropriate disposition. Enter a report of the departmental action on the current SF 600.

Eyewear Prescription (DD Form 771)

The purpose of DD form 771, *Eyewear Prescription* (fig. 12-8), is to order corrective prescription eyewear. Depending on its edition date (any of which is authorized), the DD form 771 may consist of a 3-copy carbon form (for use with pen), a 2-part carbonless form (printed on a tractor-feed printer) (fig. 12-8A), or a computer-generated form using virtual copies (fig. 12-8B). The original of the form will be sent to the optical laboratory, and a copy of the form will be placed in the patient's HREC. As with other standard forms, the DD 771 is frequently submitted via computer modem or fax, depending on availability.

Three major areas covered by the DD Form 771 are patient information, prescription information, and

EYEWEAR PRESCRIPTION		DATE 6-6-00	ORDER NUMBER
TO: (Optical Laboratory, Including ZIP Code) NOSTRA 11 Navy Street Portsmouth, VA 12345-0000		FROM: (Station & Location, Including ZIP Code) [Medical Treatment Facility Location (e.g., Eye Clinic, NAVHOSP)]	
NAME (Last, First, middle initial) GRADE AND SERVICE NUMBER/SERVICE NUMBER/SOCIAL SECURITY ACCOUNT NO. AGE DOE, JOHN R SK3 123-45-6789 35			
UNIT AND ADDRESS USS NEVERHOME (CG-10) APO 12345			
<input checked="" type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> USA <input checked="" type="checkbox"/> USN <input type="checkbox"/> USAF <input type="checkbox"/> USPHS <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> USCG <input type="checkbox"/> OTHER (Specify)			
PRESCRIPTION			
SPECTACLES: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE AVIATION SPECTACLES <input type="checkbox"/> N-15 <input type="checkbox"/> COATED <input checked="" type="checkbox"/> CLEAR OTHER: <input type="checkbox"/> REPAIR <input type="checkbox"/> PROTECTIVE MASK INSERT (Specify type and position)			
INTERPUPILLARY DISTANCE NEAR 65 / 62	EYE SIZE 48	BRIDGE SIZE 20	TEMPLE LENGTH AND STYLE 4-1/2
NUMBER PAIR(S) 2		CASE 2	
SINGLE VISION			
SPHERE	CYLINDER	AXIS	DECENTRATION IN/OUT
R +1.50	-0.75	070	
L +1.25	-0.75	070	
MULTIVISION			
ADD FOR NEAR	MULTIFOCAL INSTRUCTIONS	TOTAL DECENTRATION	
R +2.00	13MM		
L +2.00	13MM		
SPECIAL LENSES OR FRAME (Details and/or circumstances necessitating prior approval under current instructions and/or regulations. Only identical duplicate prescriptions and components should be ordered in the same DD Form 771).			
SPECIAL INSTRUCTIONS 1) SF-28 2) 5-9 FRAMES			
TYPED OR PRINTED NAME, GRADE, TITLE AND SIGNATURE OF APPROVING AUTHORITY			
TYPED OR PRINTED NAME, GRADE, TITLE AND SIGNATURE OF PRESCRIBING AUTHORITY			
DISTRIBUTION OF COPIES	CLINIC Originating Prescription - Removes Copy 3 for insertion in patient's Health Record (DD Form 722). Sends Copies 1 and 2 to designated optical laboratory. LABORATORY - Retains Copy 1 for file. Returns Copy 2 with completed spectacles.		
DD FORM 771 SEP 88	EDITION OF 1 DEC 88 WILL BE USED.		

(THIS FORM IS SUBJECT TO THE
PRIVACY ACT OF 1974 -
Use DD Form 2806.)

EYEWEAR PRESCRIPTION	DATE 2000/06/07	ACCOUNT NUMBER 000132	ORDER NUMBER 2002317
TO: (Lab)		FROM: 	
OSU PENSACOLA 450 TURNER ST. SUITE B PENSACOLA, FL 32508-		NASP BRANCH MEDICAL CLINIC 450 TURNER STREET SUITE B PENSACOLA, FL 32508-5228	
NAME (Last, First) PISTOL, JERY C.		SSN 123-45-6789	GRADE E7
ADDRESS/UNIT 123 ANYWHERE STREET		PHONE 8505551212	
ADDRESS CONTINUED		SHIP TO: <input checked="" type="checkbox"/> CLINIC <input type="checkbox"/> PATIENT	
CITY, STATE, ZIP PENSACOLA, FL 32508-5228			
AD	RES	NG	RET
X			
FRAME	EYE	BRIDGE	TEMPLE
MS9	50	20	145SKL
PD	DIST NEAR	LENS SGL VSN DIST	TINT CLEAR
68 /			
	SPHERE	CYLINDER	AXIS
R	-1.25	-0.50	110
L	-2.50	-0.75	075
MULTIVISION			
NEAR ADD	SEG HT	TOTAL DECENTER	
R		1.0	
L		1.0	
SPECIAL COMMENTS/JUSTIFICATION (*Use this space to specify blocks marked *Other.)			
PRESCRIBING OFFICER/AUTHORITY		SIGNATURE	
DISTRIBUTION: ORIGINAL - Retained by Lab. COPY 1 - Returned with eyewear. COPY 2 - Entered in health record. DD FORM 771, JUL 96 PREVIOUS EDITION IS OBSOLETE			

HM3F1208 **A** **B**
Figure 12-8.—Eyewear Prescription, DD Form 771: A. Computer-printed edition; B. Computer-generated edition.

miscellaneous information. These three areas are discussed as follows:

- 1. Patient Information:** The specific information required is the patient's name, rank, SSN, duty station, mailing address, and military status. This information is required to establish eligibility and provide the requesting activity with an address for the patient upon receipt of the completed eyeglasses.
- 2. Prescription Information:** Since the spectacle prescription is the technical portion of the order form, you should complete it with great care, ensuring that the prescription is transferred in its entirety. The essential elements of the prescription are interpupillary distance, frame size, temple length, plus and minus designators for both sphere and cylinder powers, segment powers and heights, prism, and prism base. It is not necessary to calculate decentration in the

single vision or multifocal portions of the order. It is also unnecessary to try to transpose any prescription into plus or minus cylinder form. Leave the prescription as is, copy it onto the DD Form 771, and note in the remarks section that the prescription has been copied and is in the HREC.

- 3. Miscellaneous Information:** This area is reserved for any information you feel the Navy Optical Laboratory may need. Information the laboratory may need includes special fabrication requirements, such as multifocal lenses, or proof of eligibility for specialized eyewear, such as aviator sunglasses. Standard issue items can be determined from NAVMEDCOMINST 6810.1, *Ophthalmic Services*.

DD Forms 771 should be typewritten or computer printed whenever possible. This practice eliminates

any errors by misreading an individual's handwriting. It is critical you take the time to correctly order spectacles. Omission of any information or entering erroneous information will result in a delay at the fabricating facility or a patient's receiving an incorrect pair of eyeglasses, or both.

If you cannot read what has been written on an eyewear prescription, you should contact the optometrist for clarification. In the case where the optometrist cannot be contacted, as a last effort you can send a photostatic copy of the prescription to the optical laboratory, rather than transcribing information of which you are unsure. Make sure that the copy of the prescription is accompanied by a completed DD Form 771.

VERIFYING HEALTH RECORDS

LEARNING OBJECTIVE: *Identify health record items that should be reviewed during an annual verification.*

Health records are verified annually by medical personnel having custody of the record. Health records should also be reviewed when service members report and detach from their command, and at the time of their physical examinations.

Each record should be carefully reviewed, and any errors or discrepancies should be corrected. Items to be reviewed during an annual verification include: form placement, forms order (chronological), and completeness and accuracy of patient identification data on the record jacket and on each piece of medical documentation. In addition, verify that the Privacy Act Statement has been signed, the Summary of Care form is updated (as necessary), blood group and Rh factor are documented, and currency of immunizations and accuracy of allergy documentation are complete.

Upon completion of an annual HREC verification, you should make an SF 600 entry and black-out the corresponding year block on the front leaf of the jacket with a black felt-tip pen. With this procedure, records that have not been verified during the calendar year can be identified readily and the annual verification accomplished.

CLOSING HEALTH RECORDS

LEARNING OBJECTIVE: *Recall closing procedures for health records.*

A member's health record is to be closed under the following circumstances:

- Death or declared death
- Discharge
- Resignation
- Release from active duty
- Retirement
- Transfer to the Fleet Reserve or release to inactive duty
- Missing or missing in action (MIA)(when officially declared as such)
- Desertion (when officially declared as such)
- Disenrollment as an officer candidate or midshipman

When closing an HREC, make sure the record is in order, that there are no loose papers, and all identification data is consistent. Record closing entry on the NAVMED 6150/4, *Abstract of Service and Medical History*. Include the date of separation, title of servicing activity, and any explanatory circumstances.

Upon final discharge or death, send the entire HREC and dental record 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. Make sure the original of the separation physical examination documents are included in the HREC before delivery to the command maintaining the member's service record, such as the PSD, PSA, etc. In case of death, send a copy of the death certificate along with the transmitted records.

A copy of the HREC is provided free of charge to members who requests one upon their release, discharge, or retirement.

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, then status (missing or missing in action), and supporting documentation. Close the record and handle it as you would records for members being discharged from the service.

DESERTION

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

When a deserter is apprehended or surrenders, the CO of the activity having jurisdiction is required to submit a request for the member's records to Bureau of Naval Personnel (BUPERS) or Commandant of the Marine Corps (CMC), as appropriate.

RETIREMENT

When a member of the naval service is placed on the retired list or Fleet Reserve List, close the HREC as you would on a discharge. However, upon request of the retiring member, a new medical record (OREC) is established. A **copy** of the retiring member's active duty HREC may be incorporated into a new NAVMED 6150/20-29 folder. Make an entry on an SF 600 in the HREC and in the new OREC, stating the date the HREC was closed.

DISABILITY SEPARATION OR RETIREMENT

The MTF should send a copy of the HREC of a member being separated for disability to the DVA

(Department of Veteran Affairs) regional officer nearest to where the member will be residing. Send the medical record directly from the MTF to the DVA, so the record can be considered as a primary source of evidence in processing a claim for veteran's benefits. A record carried by the member is considered secondary evidence and is not used to process a claim. Send the record with the VA 526, *Claim of Benefits*, so the regional office can initiate the claim.

Members separating from the service and eligible for veteran's benefits should be provided a copy of their HREC on request. Members should be counseled to request a copy in the event they may make a claim for veteran's benefits in the future. Always offer to send a copy of their HREC to the regional DVA office for them.

SUMMARY

As a Hospital Corpsman, you will be responsible for managing health records. Health records are a vital tool in the healthcare delivery process. It is of the utmost importance that you learn and follow guidelines for establishing, handling, maintaining, and closing health records. Keep in mind, your handling of the health record can affect others. A well-maintained health record furnishes healthcare providers with current medical data, enabling the provider to give each patient timely and comprehensive medical care. Confidential treatment of a patient's medical information honors the patient's privacy and is in keeping with legal regulations. Following the guidelines in this chapter will assist you in properly managing health records under your care.

