UNITED STATES MARINE CORPS

FIELD MEDICAL TRAINING BATTALION
Camp Lejeune, NC 28542-0042

FMST 411

MAINTAIN HEALTH SERVICES RECORDS

TERMINAL LEARNING OBJECTIVES

1. Given readiness requirements, maintain health services records to meet readiness reporting requirements. (8404-HSS-2004)

ENABLING LEARNING OBJECTIVES

1. Without the aid of reference, given a description or list, **identify the process for reviewing health records**, within 80% accuracy, in accordance with the MANMED P-117 - Manual of the Medical Department. (8404-HSS-2004a)

2. Without the aid of reference, given a description or list, **identify the corrective measures for deficiencies** with health service records, within 80% accuracy, in accordance with the MANMED P-117 - Manual of the Medical Department. (8404-HSS-2004b)

3. Without the aid of reference, given a description or list, **identify the reporting requirements** for health service records, within 80% accuracy, in accordance with the MANMED P-117 - Manual of the Medical Department and the SECNAVINST 5212.5, Navy and Marine Corps Records Disposition Manual. (8404-HSS-2004c)

1. **THE OUTPATIENT RECORD**. Navy and Marine Corps personnel and DoD eligible beneficiaries utilize the ***U.S. Navy Medical Outpatient and Dental Treatment Record*** **(NAVMED 6150/21-30)** as the official record jacket for the chronological documentation of medical and dental evaluations, care, treatments and occupational health. The medical and dental history stored in these color coded jackets assists medical department personnel to provide care.

2. **THE IMPORTANCE OF THE OUTPATIENT RECORD**. The health record has significant medico-legal value to the patient, the healthcare provider, the Medical Treatment Facility (MTF) and Dental Treatment Facility (DTF) and the U.S. Government. 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. Accurate and complete record entries and proper record maintenance are of the utmost importance.

3. **PRIMARY RECORDS**. The primary medical records are used for the documentation of outpatient medical and dental care. A secondary medical record is established by a patient's specialty healthcare provider and contains medical information needed by that provider for a specific need. Secondary medical records are maintained separate from the primary medical record.

a. The four major categories of primary medical records are:

(1) Health records (HRECs) The HREC is a file of continuous care given to *active duty members* and documents all outpatient care provided during a member's career. 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.

(2) Outpatient records (ORECs) The OREC is a file of continuous care that documents ambulatory treatment received by a *person other than an active duty person*, i.e. retiree and family members.

(3) Dental records (DRECs) are part of HRECs (active duty) and ORECs (retirees and family members). The DREC is a file of continuous care given to active duty and reserve members and their families. It contains all documents of dental care provided during a member's career.

(4) Inpatient records (IRECs) The IREC is a medical file that documents care provided to a patient assigned to a designated inpatient bed at an MTF or ship. Summaries of inpatient care are placed into the HREC (Active Duty) or OREC (non-active duty personnel) to maintain continuity of care.

4. **SECONDARY MEDICAL RECORDS**. Primary healthcare providers of active duty personnel must be aware of their personnel's medical status at all times. Thus, 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, psychology and psychiatry clinical records.

Secondary medical records are separate from the primary medical record and must follow the guidelines established by the MANMED. These records are kept in a separate file and secured in a specialty clinic or department of MTFs. Opening a secondary medical record requires the healthcare provider to write a note on the *DD Form 2766, Adult Preventive and Chronic Care Flow Sheet* in the primary treatment record. Information includes: nature of the secondary record; patient's diagnosis; and clinic or department name including address and telephone number. A note is written on the same form when the secondary record is closed.

a. Secondary medical records include:

(1) Convenience records. 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.

(2) Temporary records. 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.

(3) Temporary Dental Records. Temporary records are required to ensure the timely availability of information that documents a current course of treatment for a patient being seen in the DTF. An example is a military member on temporary additional duty (TAD) without his or her dental record who requires emergency dental treatment.

(4) Ancillary records. 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 psychiatric treatment or instances of real or suspected child or spouse abuse, etc.

5. **OPENING OF ACTIVE DUTY RECORDS**. The HREC is opened by the activity executing the original enlistment contract 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 (Fig.1) will be opened by either the Naval Training Center (NTC) or Marine Corps Recruit Depot, as appropriate. Copies of the service member's *DD 2807, Report of Medical History,* and *DD 2808, Report of Medical Examination* are sent to the appropriate NTC or recruit depot, and added to other applicable forms in the member's records.

a. A new NAVMED 6150/21-30, *U. S. Navy Medical Outpatient and Dental Treatment Record*, will be prepared when a record is opened or when the existing jacket has been damaged or is deteriorating to the point of illegibility. The old jacket will be destroyed following replacement.

b. A felt-tip or permanent black-ink pen will be used to record all identifying data, except in the "Pencil Entries" block on the upper left of the outer front cover of these medical records. Information in this block should be written in pencil, so it can be updated or changed. Figure 1 illustrates the completed outside front cover and inside back cover of a military health record jacket.

c. Each health record jacket has the second to the last digit of the social security number (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 treatment record jacket, select a pre-numbered NAVMED 6150/21-30 jacket by matching the second to the last number of the member's SSN.

(1) Enter the rest of the member's SSN on the top of the inside back cover (Part IV) as shown in Figure 2.

(2) 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.

(3) Enter the member's family member prefix (FMP) code in the two diamonds preceding the SSN on the top of Part IV. Enter the FMP code of 20 for all Navy and Marine Corps active duty members. Enter an FMP code of 00 for all foreign military personnel.

(4) 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.

(5) 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. If allergies and or sensitivities are listed ensure that all information is the same on the DREC and either the HREC (active duty) or OREC (non-active duty).

(6) Indicate the appropriate record category by entering an "X" in the appropriate box on the outside front cover, just below the "Pencil Entries" block. Indicate whether the record will be an Outpatient or Dental Treatment Record, attach ½-inch red cellophane tape to the record category block on the right edge of the inside back cover of the jacket; indicating an active duty record.

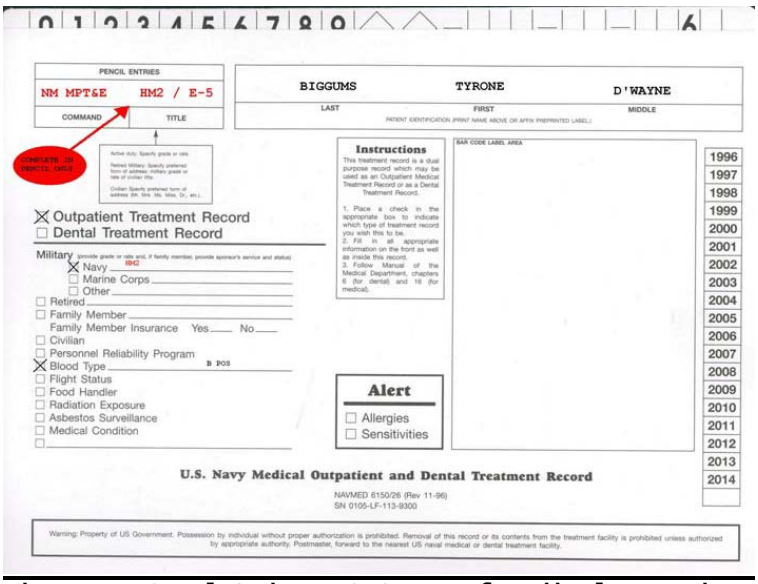


Figure 1.—Completed Front Cover of Medical Record

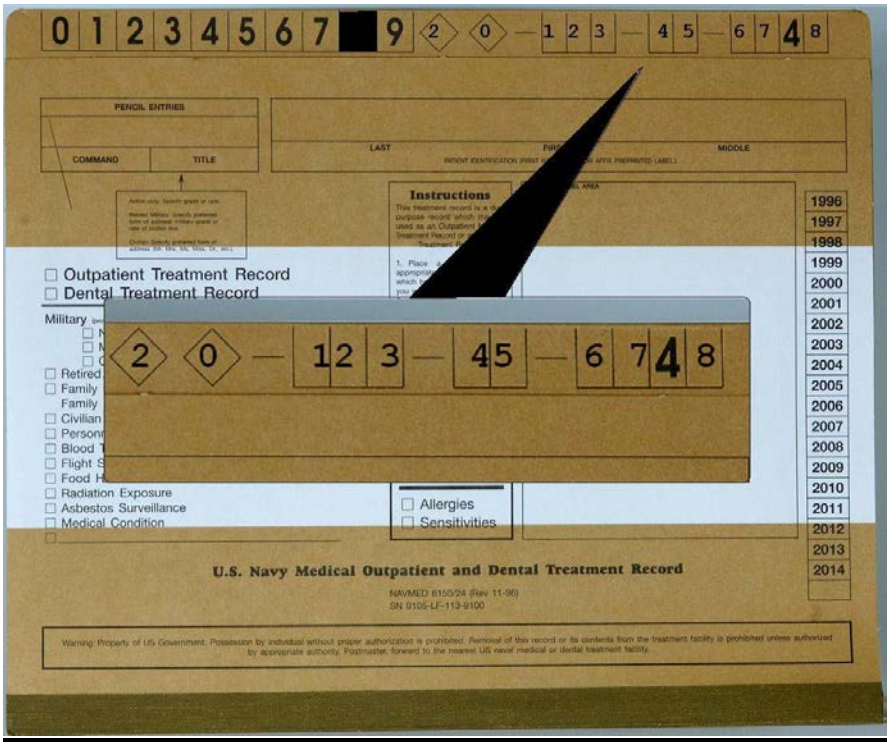


Figure 2.—Record (SSN)

(7) Below the record category area is the patient service and status box. Mark an "X" in the appropriate service block.

(8) 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.

(9) Enter the following information in pencil on the inside front cover (Fig. 3) of the record jacket. Recording the information in pencil allows changes and updating throughout a member's career.

(a) Date of arrival

(b) Projected rotation date

(c) Home address and telephone number

(d) Command UIC and telephone number

6. **Preparing Part II (Front of Center Page)**
IMPRINT OF DD 2005, PRIVACY ACT STATEMENT.— The imprint of DD 2005, Privacy Act Statement form is preprinted and located in front of the center page in the record jacket. It must be signed and dated in black ink by the patient, the parent, or the guardian must sign if the patient is a minor (Fig. 4).

7. **Preparing Part III (Back of Center Page)**
DISCLOSURE ACCOUNTING RECORD.— The Disclosure Accounting Record is preprinted and located on the back of the center page of the record jacket. It is self-explanatory and will be filled out as needed. (Fig. 5)

8. **Preparing Part IV (Inside Back Cover)**
The Forensic Examination form is preprinted and located on the inside back cover of the record jacket, and should be completed if the record is going to be used for dental care (Fig. 6).

Part I:	Summary of Care Record of Immunizations
Part II:	Chronological documentation of care (including consults, inpatient care, etc.)
Part III:	Overseas screening Boards Physical examinations Exposure forms (i.e., radiation, asbestos, etc.)
Part IV:	Laboratory/Radiology/EKG, etc. Ancillary studies

PENCIL ENTRIES ONLY!

ARRIVAL DATE		PROJECTED ROTATION DATE
LOCAL HOME ADDRESS (OR MAILING ADDRESS)		LOCAL HOME TELEPHONE
COMMAND UIC (OPTIONAL)	WORK TELEPHONE	IF A FAMILY MEMBER, SPONSOR'S WORK TELEPHONE

Figure 3.—Part I - Inside Front Cover

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you with the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

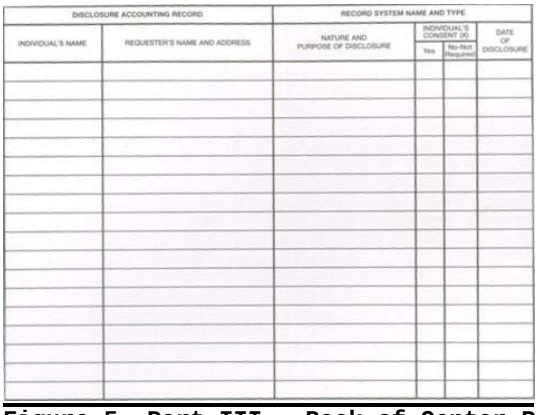
This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE

DD FORM 1 FEB 76 2005 PREVIOUS EDITION IS OBSOLETE

Figure 4.—Part II – Front of Center Page



DISCLOSURE ACCOUNTING RECORD		RECORD SYSTEM NAME AND TYPE			
INDIVIDUAL'S NAME	REQUESTER'S NAME AND ADDRESS	NATURE AND PURPOSE OF DISCLOSURE	INDIVIDUAL'S CONSENT (X)		DATE OF DISCLOSURE
			Yes	No-Not Required	

Figure 5.—Part III – Back of Center Page

Figure 6.—Part IV - Inside Back Cover

9. **VERIFICATION OF ACTIVE DUTY HEALTH AND DENTAL RECORDS**

a. All records are verified annually by medical and dental personnel having custody of them. Health records will be

reviewed when service members report and detach from their commands, and at the time of any physical examinations.

b. Each record will be carefully reviewed and any errors or discrepancies corrected. Items to be reviewed during any verification include: form placement, order of forms (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 DD 2766 is updated as necessary, operational and occupational requirements updated, and currency of immunizations and accuracy of allergy documentation are complete.

c. Upon completion of an annual medical record verification, the HM will make an entry on the SF 600 for medical records 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 and the annual verification accomplished. The annual verification section is located on the right-hand side of the front cover of the record jacket as a series of blocks numbered with the years 1996 thru 2014. The year of verification will be blackened out for health records once it has been verified.

d. For dental records, document verification on the EZ603A and as they are verified at the time of the annual exam there is no requirement to blacken the verification year. The information on the inside of the jacket front cover should be updated in pencil only for both records. This information will be entered at the time of record check-in (receipt) and will be kept current at all times by erasing previous, outdated entries.

10. **CLOSING THE HEALTH RECORD**. (see figure 8) A member’s health records may be closed due the following circumstances:

a. Death or declared death

b. Discharge

c. Resignation

d. Release from active duty

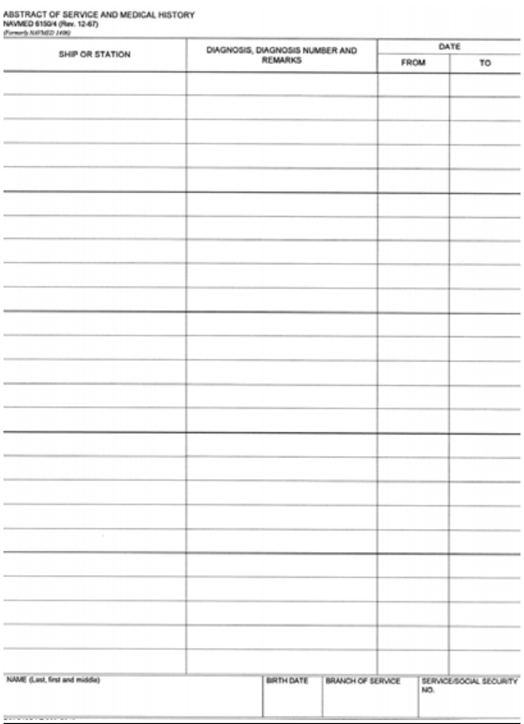
e. Retirement

f. Transfer to the Fleet Reserve or release to inactive duty

g. Missing or missing in action (MIA; when officially declared as such)

h. Desertion (when officially declared as such)

i. Disenrollment as an officer candidate or midshipman


ABSTRACT OF SERVICE AND MEDICAL HISTORY
NAVMED 6150/4 (Rev. 12-67)
(Formerly NAVMED 1406)

SHIP OR STATION	DIAGNOSIS, DIAGNOSIS NUMBER AND REMARKS	DATE	
		FROM	TO

NAME (Last, first and middle)	BIRTH DATE	BRANCH OF SERVICE	SERVICE/SOCIAL SECURITY NO.

Figure 8.—NAVMED 6150/4

11. **REPORTING**. To inform appropriate officials of any actual, impending, or threatened unlawful removal, alteration, or destruction of Federal records; and the sanctions provided for the unlawful removal or destruction of Federal records.

REFERENCE(S):
Dental Health Care BUMEDINST 6600
Department of the Navy Records Management Manual SECNAVINST 5210.1
Deployment Health DODI 6490.03
Joint Medical Surveillance DoD Directive 6490.2
Manual of the Medical Department MANMED P-117
Navy and Marine Corps Records Disposition Manual SECNAVINST 5212.5_