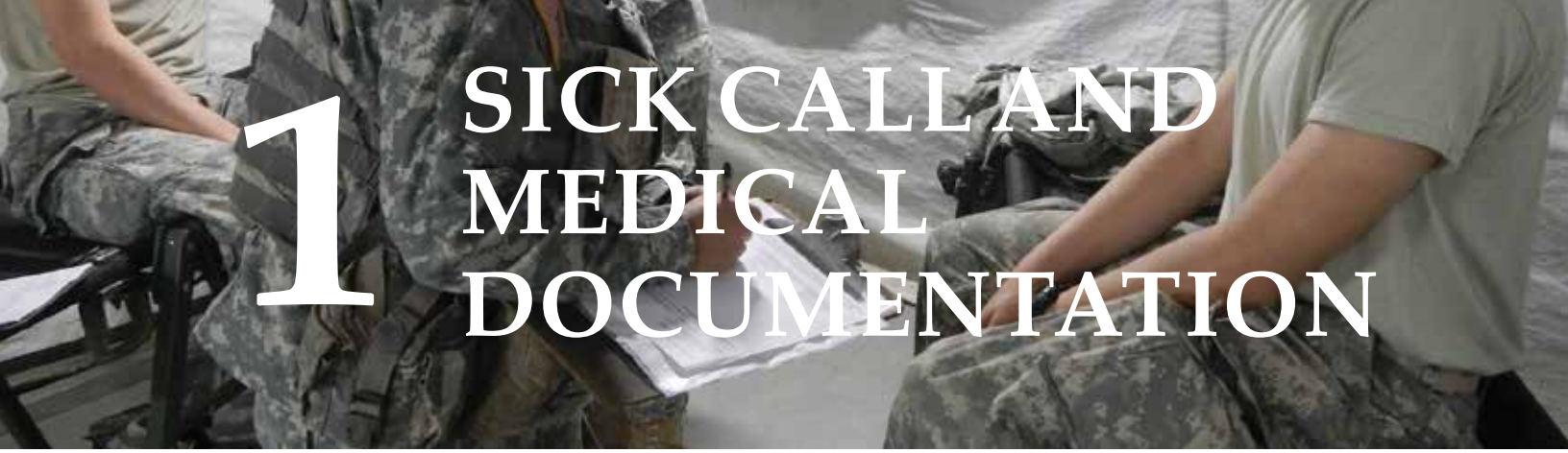


1 SICK CALL AND MEDICAL DOCUMENTATION

CORE CONCEPTS

- Explain documentation requirements in the clinical setting.
- Utilize the sick call process.
- Identify critically ill patients.
- Document medical care in a medical record.
- Define the SOAP method.
- Identify the documentation forms used in the clinical setting.
- Interpret HIPAA restrictions on how patient information is used or distributed.

INTRODUCTION

Knowledge of sick call procedures and the principles of accurate patient care documentation are bedrock concepts of military medical care. Entries written in a patient's medical record are part of a legal and permanent written document. Accurate observation and documentation of the patient's symptoms and your observations are critical to appropriate treatment and recovery. If documentation is incomplete or poorly entered into a medical record, a patient may receive improper or potentially harmful care. The information that is documented in a medical record is used by physicians, nursing personnel, and physician assistants to plan, implement, and evaluate a patient's course of treatment. This chapter will provide you with an overview of sick call concepts and procedures as well as an opportunity to learn and practice a crucial part of the medical record documentation (Figure 1-1).

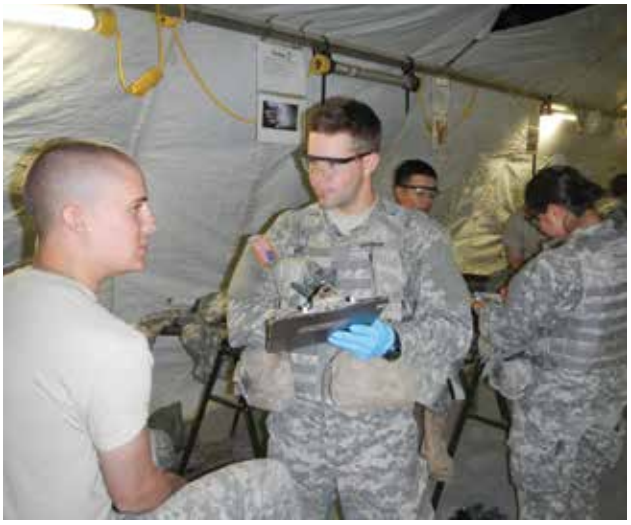


Figure 1-1. Combat medics are performing sick call procedures (SOAP note writing) during War Days Battalion Aid Station training.

FORMS USED DURING THE SICK CALL PROCESS

The Department of Defense (DD) Form 689, Individual Sick Slip (Figure 1-2), is used when initiating the sick call process. This form is used when a soldier requests or receives medical or dental treatment at an Army medical treatment facility (MTF). In addition, the DD Form 689, Individual Sick Slip, is also used as a means of communication between medical personnel and the patient's commander.

Use Standard Form (SF) 600, Chronological Record of Medical Care (Figure 1-3) to document the chronological record of outpatient treatment. Include date, time of visit or entry, MTF involved, and the signature of the person making the entry.

INDIVIDUAL SICK SLIP

☒ ILLNESS ☐ INJURY

DATE: 20140220

LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT		ORGANIZATION AND STATION
Doe - John - J.		C 3/327 Inf FT Campbell, KY
SERVICE NUMBER/SSN: 123-45-6789	GRADE/RATE: E-1	

UNIT COMMANDER'S SECTION	MEDICAL OFFICER'S SECTION
IN LINE OF DUTY	IN LINE OF DUTY
REMARKS Sore throat.	DISPOSITION OF PATIENT ☐ DUTY ☒ QUARTERS ☐ SICK BAY ☐ HOSPITAL ☐ NOT EXAMINED ☐ OTHER *(Specify)*: REMARKS Quarters for 48 hours. Follow-up at 0630 on 22 February 2014.
SIGNATURE OF UNIT COMMANDER for Michelle Held, SFC, 187th SDNCO	SIGNATURE OF MEDICAL OFFICER [illegible] PA-C

DD FORM 689, MAR 63 PREVIOUS EDITIONS ARE OBSOLETE.

Figure 1-2. The Department of Defense Form 689 (Individual Sick Slip) documents patient identification, administrative data, and information about the injury or illness.

Check on Learning

1. What is the purpose of DD Form 689?
2. What is the purpose of SF 600?

MAKING MEDICAL ENTRIES ON STANDARD FORM 600

When documenting information on an SF 600, follow the requirements below for each entry:

- Legibly typed or handwritten in black or blue-black ink.
- Signed by the individual who made the entry (sign above printed name and title). For the military personnel signature block, sign with full payroll signature, rank, military occupational specialty, and branch of service. For the civilian personnel signature block, sign with full payroll signature, title, and grade scale level (pay grade).
- Dated in the day-month-year sequence (eg, 25 SEP 2016).
- Capitalized (the first word of each entry).
- Written with present- or past-tense verbs.
- Recorded as soon as possible.
- Written using only approved abbreviations in accordance with Army Regulation 40-66 (Figure 1-4).
- Clear, concise, and objective.

To correct an entry error, draw a single line through the information, write "error," and initial (Figure 1-5). If the documentation was completed but information must be changed, add the correct information, the reason for the change, and the date and signature block of the person making the change.

Note: When documenting patient care on a patient report **do not**:

- erase or use correction fluid,
- skip lines,
- write between lines,
- document information for someone else, or
- leave blank lines above the signature.

Check on Learning

3. To save time, Specialist Fry invented several abbreviations to document patient care. Now his patient care documentation is quick, and the time saved is used to help restock shelves with supplies. Is this a good practice?

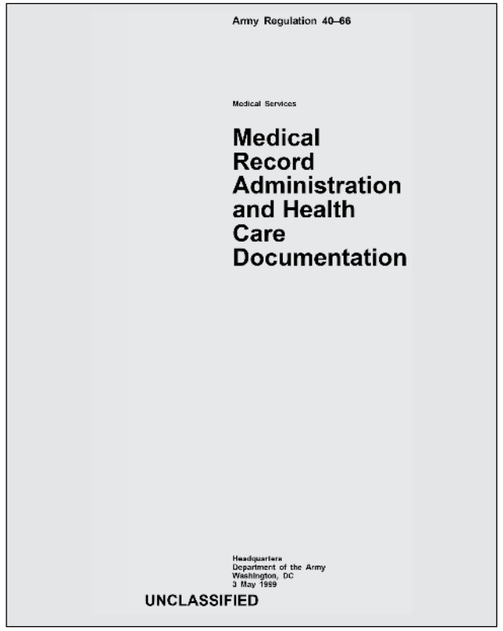
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

Figure 1-3. Standard Form 600 (Chronological Record of Medical Care) is filed in the patient's medical record and is the primary form that documents patient assessment and treatment at the medical treatment facility.



Army Regulation 40–66

Medical Services

Medical Record Administration and Health Care Documentation

Headquarters
Department of the Army
Washington, DC
3 May 1999

UNCLASSIFIED

Figure 1-4. Army Regulation 40-66 (Medical Record Administration and Health Care Documentation) provides policies for preparation and use of medical reports and records.

INITIATING THE SICK CALL PROCESS

The individual soldier obtains a DD Form 689 (Individual Sick Slip) from his or her first-line supervisor (section sergeant or platoon sergeant) to present to sick call. This ensures that accountability is maintained at the MTF and within the soldier's unit. Once the soldier obtains a DD 689, he or she proceeds to the MTF.

On arrival, the soldier is signed into a daily disposition log. This log is usually maintained by a combat medic. The combat medic will note the soldier's name, unit/section, time of arrival, reason for the visit, and (upon departure) disposition (return to duty or any **profile** issued). The combat medic retrieves the soldier's medical records, stored at the MTF, and initiates an entry on the SF 600 (Chronological Record of Medical Care). The soldier's vital signs, chief complaint, medical history, assessment, and treatment are also documented on the SF 600. **SOAP** is a useful acronym that represents subjective, objective, assessment, and plan. These are the four main areas that cover patient assessment and treatment. Protocol is established by the MTF's medical officer (MO) for the extent of medical history and physical examination that the combat medic will elicit prior to the soldier's evaluation by the MO (Figure 1-6).

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Mar 12	S: 24 y.o. AD male c ~~2~~ error MWD 1 day hx of (L) ankle pain p ruck march. No previous trauma / surgery.
P 98	↓ strength in (L) foot 2° to pain. Patient stated
BP 111/78	"I was ruck marching when I stepped on a rock and
R 14	rolled my ankle."

Figure 1-5. Occasionally entries on the Standard Form 600 (Chronological Record of Medical Care) may be incorrect due to transcription error, misunderstanding, or other reasons. The proper way to correct a mistake on the form is shown here.

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Mar 12	S: 24 y.o. AD male c ~~2~~ error MWD 1 day hx of (L) ankle pain p ruck march. No previous trauma / surgery.
P 98	↓ strength in (L) foot 2° to pain. Patient stated
BP 111/78	"I was ruck marching when I stepped on a rock and
R 14	rolled my ankle."
T 98.8	O: Soldier carried into clinic by other Soldiers.
O2 97% room air	Patient unable to walk 5 assistance. Marked STS
	over entire ankle c bruising over (L) lateral calf,
A: NKDA	ankle and foot. ↓ ROM all areas 2° to pain.
M: Motrin	Good pulses distal to injury. Cap refill < 2 seconds.
P: None	TTP over bony prominence of (L) lateral malleolus.
L: Water &	Positive Anterior Drawer and Inversion Talar Tilt
Gatoraid	Test.
E: Ruck march	A: (L) lateral ankle sprain R/O fx. R/O achilles
	tendon tear.
	P: Refer to M.D. Michael McDavis PFC 68W

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY/ID NUMBER	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*

REGISTER NUMBER | WARD NUMBER

Doe, John J.
123-45-6789
Male
19880201
PFC / E-3

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 11/2010)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

PREVIOUS EDITION IS NOT USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

Figure 1-6. This Standard Form 600 (Chronological Record of Medical Care) is filled out in the SOAP note format. Documentation may be subject to local standard operating procedures, so combat medics should make sure that they are following the correct format and style for their unit or medical treatment facility.

EARLY IDENTIFICATION OF CRITICALLY SICK PATIENTS

Most patient encounters during sick call are not emergencies. However, a small number of patients will present with signs or symptoms that could indicate a serious underlying disease or injury. In the clinical setting, triage is defined as "the sorting of patients and setting priorities for treatment in urgent care settings, emergency departments, clinics, hospitals, health maintenance organizations, or in the field."[1] For example, headache, nausea, and sensitivity to bright light are signs and symptoms that are experienced by patients who have migraine headaches, as well as those who have bacterial meningitis. The signs and symptoms useful for identifying bacterial meningitis are fever and the inability to touch the chin to the chest. A properly conducted triage will differentiate between the two conditions and ensure that the patient with bacterial meningitis is seen first by the MO. Look for patients with worrisome signs and symptoms to ensure they are the priority for evaluation by an MO (Figure 1-7). If a patient is suspected of being critically ill, take the following steps:

- Obtain the patient's chief complaint (reason for reporting to sick call) on his or her arrival to the MTF. Identify any patients with signs and symptoms that have increased potential for complications. Examples include:
  - headache,
  - acute vision changes,
  - neck pain or stiffness,
  - chest pain,
  - shortness of breath,
  - abdominal pain, and
  - altered mental status.
- Promptly obtain vital signs and notify the MO of these results and the signs and symptoms. If the situation permits, examine related body areas (in accordance with your skill level and training). If in a garrison environment, be familiar with the procedures for activating emergency medical services.

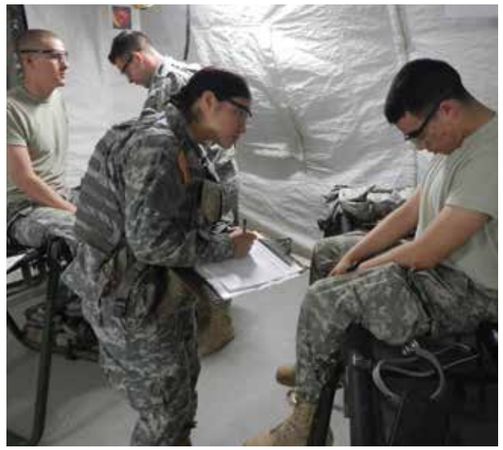


Figure 1-7. This combat medic is triaging a patient for possible meningitis during War Days Battalion Aid Station training. If the disease is suspected, the patient becomes a priority for examination by a medical officer.

HISTORY-TAKING TECHNIQUES

Use the SOAP method to ensure that the main components of the patient history are addressed. Use the following skills to gather an accurate patient history:

- **Observe**. Begin observing the soldier as soon as he or she walks through the door.
- **Listen**. Listen carefully. (This will help in determining the cause of the problem.)
- **Ask open-ended questions**. Open-ended questions help you obtain more complete and accurate information. For example, "What does the pain feel like?" is more useful than asking, "Does the pain feel like an elephant is sitting on your chest?"

Common obstacles to compiling an accurate patient history include the following:

- **Provider obstacles**. Providers' attitudes or predeterminations may hinder their ability to make accurate judgments. A patient seen repeatedly at an aid station who rarely has identifiable problems can be a challenge. It must be assumed that every patient has a legitimate complaint at each visit. This ensures that a significant illness or injury is not missed.
- **Patient obstacles**. Patients may also have obstacles to overcome. They must have confidence in their medical care. Soldiers seeking medical evaluation and treatment have expectations that may or may not be realistic. For instance, patients without medical training will very often request specific diagnostic studies such as radiographs, blood tests, and referrals to specialists in situations where they are not warranted. Asking the right questions will get more information and the answers received will direct the physical examination. Maintain a high index of suspicion. This requires paying close attention to reported symptoms and considering all possibilities that could account for them. Any injury reported by the patient should raise or lower your index of suspicion about the potential severity of the injury. For example, a patient complaining of pain after twisting a knee while running probably has less potential for a significant injury than a patient who twisted a knee following a parachute-landing fall.

Obtain Subjective Information from a Patient

Subjective information is provided by the patient. It is needed to obtain a relevant history of the patient's present or past related symptoms or chief complaint. This information is not necessarily found in an examination; it may be what the patient reports feeling and it is usually documented in direct quotes from the patient. Subjective information includes the following:

- age, sex, race, and first day of last menstrual period (FDLMP) for all female patients of child-bearing age;
- chief complaint (the patient's stated reason for the visit)—for example, "I twisted my ankle while running this morning";
- history of present illness (all the information relevant to the patient's chief complaint);
- past medical history (any significant medical diagnosis or disease condition the patient has, such as hypertension or diabetes);
- past surgical history (any significant surgical procedures that have been performed, such as appendectomy, tonsillectomy, or cesarean delivery);
- social history (patient's use of tobacco, alcohol, and illegal substances);
- occupation and leisure activities may be relevant and are entered as social history;
- last oral intake (the last thing the patient had to eat or drink and when it was consumed); and
- events or situation leading up to illness or injury, if known. For example, "I was driving 30 mph without a seatbelt when my car hit a car stopped in front of me."

The following are the principal components of the chief complaint. They can be remembered easily with the acronym **OPQRST**:

- **Onset.** Sudden? Gradual? Specific injury or activity?
- **Provoking or palliative factors.** What makes it worse or better?
- **Quality.** What does the pain feel like? Sharp? Dull?
- **Radiation or region.** Where is the pain? Is it localized to one area?
- **Severity.** How would you score the pain on a scale of 1 to 10 (with 10 being the worst pain the patient has ever had)? Does it limit activity?
- **Timing.** Duration? Is the pain intermittent? Constant?

Past history involves information that may contribute to understanding the present illness or injury. This information may be helpful in determining possible causes of the chief complaint or rule out other possible causes, and it may also impact your treatment decisions. The acronym **SAMPLE** provides an easy way to remember the components of past history:

- signs and symptoms;
- allergies;
- medications;
- past medical, surgical, and social history;
- last oral intake; and
- event leading up to illness or injury.

Check on Learning

4. List four subjective information components.

Obtain Objective Information about the Patient

Objective information is data obtained by the combat medic or medical provider through the use of the senses, such as sight, sound, touch, hearing, and smell. Use medical instruments to quantify the data. Ensure that nothing from the soldier's comments or history is recorded in this section. Collect and record the following clinical measurements and vital signs:

- height,
- weight,
- pulse,
- respiratory rate,
- blood pressure,
- temperature, and
- oxygen saturation (pulse oximetry reading).

"General impression" (GEN) is a statement of the combat medic's initial notion of the current state of the patient's general health. For example, the combat medic might write, "GEN-patient appears or seems to be in no acute distress (NAD)," or "GEN-patient appears to be in severe pain."

When performing a physical exam of the patient, start with the body area that is related to the information annotated in the subjective area of the SOAP note. If a patient presents with an altered mental status or shock, conduct a complete head-to-toe assessment to rule out hemorrhage or trauma. Assess the following areas of the body to obtain information for the SF 600:

- **Orthopedic**
  - Inspection. To localize pain, ask the patient to place a finger on the spot that hurts. Look for edema, ecchymosis, erythema, atrophy, deformities, and posture. Compare the affected extremity to the unaffected one. Observe the patient walk and analyze the gait and arm swing. Determine if the patient can apply weight to the extremity. An acronym to use when inspecting each body area is **DCAP-BTLS**. This acronym represents deformities, contusions, abrasions, punctures and penetrations, burns, tenderness, lacerations, and swelling.
  - Palpation. Palpate the affected area for tenderness and temperature changes; assess for pulse, motor, and sensory deficit (PMS).
  - Range of motion (ROM). Assess the range of motion of the affected and unaffected extremities, neck, and back. Document any decreased range of motion on the SF 600.
  - Muscle strength. Note differences in muscle strength through resistance tests.
  - Special tests. Observing how a patient reacts to stretching or stress on a joint and tissue may make the evaluation more efficient and provide valuable clues to the diagnosis. There are many special tests for specific anatomical injuries and disorders.
- **Skin**
  - Inspection. Note the general color of the skin, vascularity, and evidence of bleeding or bruising.
  - Palpation. Assess the temperature and general condition of the skin.
  - Observe any lesions of the skin. Note anatomical location, distribution, grouping, type, and color.
- **Eyes, Ears, Nose, and Throat**
  - Inspect and palpate external and internal (where applicable) structures of the eyes, ears, nose sinuses, and throat for DCAP-BTLS and foreign bodies.
  - Special tests. Visual acuity and pupillary reaction of the eyes or other special tests may be indicated.
- **Chest (Respiratory)**
  - Inspect and palpate both the anterior and posterior thorax for DCAP-BTLS.
  - Note the rate, rhythm, and quality (effort) of breathing.
  - Auscultate breath sounds bilaterally.
- **Abdomen**
  - Ask the patient to point to the painful areas and examine those last.
  - Inspect for DCAP-BTLS and **TRD-P** (tenderness, rigidity, distention, and pulsating masses).
  - Auscultate each of the four abdominal quadrants for the presence of bowel sounds. The peristaltic action of the bowel produces 5 to 34 clicks or gurgles per minute in each quadrant.

Complete an Assessment

Document the presumptive diagnosis based on the history and physical examination findings. If unsure of the diagnosis, simply restate the patient's chief complaint. For example, "A- R knee pain" means Assessment- Right knee pain. The goal is to restate the patient's chief complaint.

Check on Learning

5. List four objective information components.
6. If you are unable to assess the patient's specific problem, what should you write?

Develop a Treatment Plan

The treatment plan should include courses of action relevant to the assessment of the patient. Treatment plans may include the following:

- medications and dosages, as prescribed by the MO or from standard operating procedures (SOPs);
- specific duty and activity restriction (profile) if applicable; and
- special actions if any, such as ice or heat, compression, elevation, splint, or crutches.

Refer all **RED FLAGS** to an MO. The entire treatment plan may be as simple as "P- Refer to MO." The treatment plan should state when the patient should return for a follow-up evaluation. Every SOAP note should include the circumstances under which the patient should return to an MTF. For example, "Return to clinic (RTC) if symptoms persist, worsen, or new symptoms develop."

PROFILES

A physical profile defines, in writing, limitations to physical activity due to injury, illness, or medical condition. The authorized forms for written profiles in the Army are the DD Form 689 (Individual Sick Slip) and DA Form 3349 (Physical Profile). DA Form 3349 is preferred over DD Form 689 because it requires a much more detailed description of the soldier's condition and the activities and exercises that he or she can perform. Soldiers may be assigned to a reconditioning program. Such soldiers include those who are on temporary medical profile, are in their recovery period after temporary profile expiration, or are on permanent medical profile with specific limitations or special fitness requirements.

Unless specifically authorized by the supervising MO and local protocol, combat medics are not authorized to issue profiles, **quarters**, or **bed rest**. Medical care providers will follow the local protocols and consult with or refer to an MO when the plan section of this medical documentation suggests a profile or quarters. Profiles should be written in nonmedical language and should be specific concerning physical limitations. Profiles should contain a specific expiration date, for example, "*no running until 15 April.*" Profiles that contain terms such as "× 14 hrs" or "× 3 days" may be misunderstood, particularly if the patient was seen in the afternoon or on a Friday. When writing for quarters, if the plan calls for quarters for 48 hours, write: "*24 Sep 2016 to 25 Sep 2016. Return to MTF at 0630 on 26 Sep 2016.*"

The term "quarters" means restriction and rest in the patient's place of domicile. It should allow the patient freedom of movement within the living space, including common areas such as the day room. Patients on quarters may not perform military duties. Quarters will not normally exceed 72 hours. The term "bed rest" means the patient is restricted to their bed, with allowances for necessary travel to the dining facility and latrine. Patients on bed rest may not perform any military duties. Further restriction is determined on a case-by-case basis. The term "duty" means the patient is returned to his unit for full duty without any restrictions. Army Directive 2016-07 (Redesign of Personnel Readiness and Medical Deployability) forces commanders to follow profile instructions shown in Figure 1-8**.**

Check on Learning

7. What is the difference between quarters and bed rest?
8. Can a commander force a soldier to break a profile?
9. If you do not know the nature of the patient's medical problem, what should you write for the plan?

PATIENT CONFIDENTIALITY

On August 21, 1996, President Bill Clinton signed into law the Health Insurance Portability and Accountability Act (**HIPAA**). This federal law protects the privacy of patient-specific health care information and gives the patient control over how this information is used and distributed. The Military Command Exception allows a covered entity to disclose personal health information (PHI) of service members to their commanders. This exception does not constitute a requirement and only permits the disclosure. When PHI of a soldier is disclosed, only the minimum amount of information necessary is provided. The military command exception does not allow a commander to directly access a soldier's medical record. Examples of activities for which PHI may be disclosed to a commander are determining a soldier's fitness for duty, the performance of a particular assignment, and the soldier's ability to carry out any other activity essential for the military mission. Medical confidentiality must be protected as fully as possible for all patients. Access to medical information may be given to the patient, patient care personnel, medical researchers, public health professionals, and medical educators. Do not discuss patient information within hearing range of other patients or with unauthorized personnel. Unauthorized disclosure of medical information is subject to federal law. Action can also be taken against the offender under the Uniform Code of Military Justice (UCMJ). Personnel not involved in a patient's care or in medical research may not have access to patient information unless the following situations apply:

PHYSICAL PROFILE

For use of this form, see AR 40-501; the proponent agency is the Office of the Surgeon General.

1. MEDICAL CONDITION: *(Description in lay terminology)* ☐ INJURY? Or ☒ ILLNESS/DISEASE?	2. CODES *(Table 7-2 AR 40-501)*	3.	P	U	L	H	E	S
	B	Temporary						
		Permanent	1	1	2	1	1	1

4. PROFILE TYPE	YES	NO
a. TEMPORARY PROFILE *(Expiration date YYYYMMDD)* *(Limited to 3 months duration)*	☐	☒
b. PERMANENT PROFILE *(Reviewed and validated with every periodic health assessment or after 5 years from the date of issue)*	☒	☐

5. FUNCTIONAL ACTIVITIES THAT EVERY SOLDIER REGARDLESS OF MOS MUST BE ABLE TO PERFORM. IF SOLDIER CANNOT PERFORM ANY ONE OF THESE TASKS, THEN THE PULHES MUST CONTAIN AT LEAST ONE "3" AND SOLDIER MUST BE REFERRED TO A MEB. CAN THE SOLDIER:

FUNCTIONAL ACTIVITY:	YES	NO
a. Carry and fire individual assigned weapon?	☒	☐
b. Evade direct and indirect fire?	☒	☐
c. Ride in a military vehicle for at least 12 hours per day?	☒	☐
d. Wear a helmet for at least 12 hours per day?	☒	☐
e. Wear body armor for at least 12 hours per day?	☒	☐
f. Wear load bearing equipment (LBE) for at least 12 hours per day?	☒	☐
g. Wear military boots and uniform for at least 12 hours per day?	☒	☐
h. Wear protective mask and MOPP 4 for at least 2 continuous hours per day?	☒	☐
i. Move 40lbs (for example, duffle bag) while wearing usual protective gear (helmet, weapon, body armor and LBE) at least 100 yards?	☒	☐
j. Live in an austere environment without worsening the medical condition?	☒	☐

6. APFT	YES	NO	ALTERNATE APFT *(Fill out if unable to do APFT run otherwise N/A)*	N/A	YES	NO
2 MILE RUN	☐	☒	APFT WALK	☐	☒	☐
APFT SIT-UPS	☐	☒	APFT SWIM	☐	☐	☒
APFT PUSH UPS	☒	☐	APFT BIKE	☐	☒	☐

7. DOES THE SOLDIER MEET RETENTION STANDARDS IAW CHAPTER 3 AR 40-501?

YES ☐ NEEDS MMRB NO ☐ NEEDS MEB

8. FUNCTIONAL LIMITATIONS AND CAPABILITIES AND OTHER COMMENTS:

Back pain (L2) 3-39h.

☐ This temporary profile is an extension of a temporary profile first issued on _____

9. NAME, GRADE & TITLE OF PROFILING OFFICER	10. SIGNATURE	11. DATE *(YYYYMMDD)*
CIV Michael Davis, MD, -1	DAVIS.MICHAEL.WAYNE.	20140220
12. NAME & GRADE OF APPROVING AUTHORITY	13. SIGNATURE	14. DATE *(YYYYMMDD)*
<<Approval not required>>		

15. Commanders can access the electronic profiles of Soldiers in their unit(s) by going to http://www.mods.army.mil/ and clicking on eProfile in the list of applications. Commanders will be required to register and be approved in eProfile before they can gain access to profiles.

16. PATIENT'S IDENTIFICATION		17. HOSPITAL OR MEDICAL FACILITY
a. NAME: *(Last, First)*	Doe, John J.	Anywhere Medical Center
b. GRADE/RANK:	E-7 / SFC	
c. SSN:	123-45-6789	
d. UNIT:	C Co, 3/327th Inf, 101st ABN	18. PROFILING OFFICER E-MAIL: mdavis1234@anymilitaryinstallation.mil

DA FORM 3349, SEP 2010 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 2 APD PE v1.00ES

Figure 1-8. Department of the Army Form 3349 (Physical Profile) may be used to document temporary or permanent medical conditions that limit a soldier's functional or physical fitness activities.

- access is required by law (court order),
- access is needed for hospital accreditation, or
- access is authorized by the patient.

All requests for medical information are done in writing except in emergency situations. This information is handled by patient administration personnel and is not provided by the combat medic.

Check on Learning

10. First Sergeant Williams approaches the desk while you are conducting sick call triage. He tells you to print and provide him with all medical records for Private Shaffer. Should you provide the records? Why or why not?
11. If someone other than the patient requests copies of medical records, where should the request be directed?

SUMMARY

Properly executing sick call procedures and medical documentation can be some of the most challenging tasks conducted by a combat medic. The general rule of thumb is if treatment was not documented then that treatment was not performed, regardless of what is said. All paper or electronic documentation must be filed in the patient's medical records.

The importance of documentation and communication cannot be overstated. The ability to identify a critically ill or injured patient early in the sick call process can save lives and speed up a soldier's return to the unit. Precise attention to detail will ensure that all assessment findings and treatment are annotated on the appropriate forms. Improper sick call procedures, as well as improper documentation, can have devastating and long-lasting effects on a soldier's future.

KEY TERMS AND ACRONYMS

Bed rest. The patient is restricted to his or her bed, with allowance for necessary travel to the dining facility and latrine.
DCAP-BTLS. Deformity, contusion, abrasion, punctures and penetrations, burns, tenderness, lacerations, and swelling; used when performing an exam of each body part during the combat casualty assessment.
HIPAA. The Health Insurance Portability and Accountability Act; a federal law protecting the privacy of patient-specific health care information and providing the patient with control over how this information is used and distributed.
MO. Medical officer.
OPQRST. Onset, provoking or palliative factors, quality, radiation or region, severity, and timing; used to obtain patient history information.
Profile. Limitations to physical activity due to injury, illness, or medical condition.
Quarters. Restriction and rest in the patient's place of domicile.
RED FLAGS. Signs and symptoms that require immediate referral to a medical officer.
SAMPLE. Signs and symptoms; allergies; medications; past medical, surgical, and social history; last oral intake; and event leading up to illness or injury. Used to note past history.
SOAP. Subjective, objective, assessment, and plan; used help the combat medic complete the patient note.
TRD-P. Tenderness, rigidity, distention, and pulsating masses.

CHECK ON LEARNING ANSWERS

1. What is the purpose of DD form 689?

   To request medical treatment and provide communication between commanders and medical personnel.

2. What is the purpose of SF 600?

   It is a form used for medical documentation.

3. In order to save time, Specialist Fry has invented several abbreviations to document patient care. Not only is his patient care documentation completed quickly, but the time saved is used to help restock shelves with supplies. Is this a good practice?

   No. You should only use approved abbreviations in accordance with Army Regulation 40-66.

4. List four subjective information components.

   Any four of the following: age, sex, race, and first day of last menstrual period (FDLMP) for all female patients of child-bearing age, chief complaint, SAMPLE history, social history, and any OPQRSTI information.

5. List four objective information components.

   Vital signs, patient's height and weight, and any physical exam findings.

6. If you are unable to assess the patient's specific problem, what should you write?

   Restate the patient's chief complaint.

7. What is the difference between quarters and bed rest?

   Patients on bed rest may use the dining facility.

8. Can a commander force a soldier to break a profile?

   No. It is prohibited by Army Directive 2016-07.

9. If you do not know the nature of the patient's medical problem, what should you write for the plan?

   P–Refer to MO.

10. First Sergeant Williams approaches the desk while you are conducting sick call triage. He tells you to print and provide him with all medical records for Private Shaffer. Should you provide the records? Why or why not?

    No. Health Insurance Portability and Accountability Act (HIPAA) protects Private Shaffer's records. Respectfully inform First Sergeant Williams his request for patient care records must be made to the Patient Administration Office and inform your physician assistant of the conversation.

11. If someone other than the patient requests copies of medical records, where should the request be directed?

    The request should be sent to the patient administrator.

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