

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE	OTSG APPROVED (Date)
SCREENING CHECKLIST FOR SRP	16 January 1996

ITEM	REQUIREMENT	SRP DATE	SRP DATE	SRP DATE	SRP DATE	SRP DATE	SRP DATE
GENERAL (DATE)							
Physical	Every 5 years (Starting at age 30.)	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
Eye exam	Every 2 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing exam	Every 2 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIES		<input type="checkbox"/> Yes <input type="checkbox"/> No					
DA Label 162	If required	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
DA Form 3365/tags	If required	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
LABORATORY							
DNA	Once	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood type	Type: Once	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
HIV	Every <input type="checkbox"/> 6 Mos <input type="checkbox"/> 2 Yrs	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
G-6PD		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCG (pregnancy test)		<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
REQUIRED IMMUNIZATIONS							
Polio	Once as adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMR	Once as adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPD	Every 2 years, or 3 mos prior to OCONUS travel. Every year for MEDDAC, Vet Svcs, and PROFIS.	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
Tetanus - Diphtheria	Every 10 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningococcal	Enlistees/endemic areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A No. 1	Endemic areas/RD units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A No. 2	Endemic areas/RD units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid - only 1 Type required (check one)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Typhoid	Every 3 years						
<input type="checkbox"/> Typhoid Oral	Every 5 years						
<input type="checkbox"/> Typhoid VI	Every 2 years						
PROVISIONAL IMMUNIZATIONS							
Hepatitis B #1 (medical personnel/high risk only)	For medical personnel and high risk group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B #2 (high risk)	1 month after #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B #3 (high risk)	6 months after #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Japanese Encephalitis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthrax		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A check in any box in the "SRP Date" columns indicates a deficiency. A date is entered under "SRP Date" if a deficiency has been corrected or is pending.

Soldiers are considered non-deployable if anything is pending.

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL FLOW CHART
- OTHER EXAMINATION OR EVALUATION OTHER (Specify)
- DIAGNOSTIC STUDIES
- TREATMENT

ITEM	REQUIREMENT	SRP DATE					
CHECKED AT THE SRP SITE							
Warning tags (2)	If needed or ordered	<input type="checkbox"/> P					
Glasses (2 pair)	If needed or ordered	<input type="checkbox"/> P					
Protective mask insert	If needed or ordered	<input type="checkbox"/> P					
Hearing aid	If needed or ordered	<input type="checkbox"/> P					
Hearing aid batteries	If needed or ordered	<input type="checkbox"/> P					
Profiles or Quarters (Level 3/4)	Check if "Yes"	<input type="checkbox"/>					
SRP DEPLOYABLE? (Circle "YES" or "NO")		YES NO P					

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PRE-SCREENING

Medical records screened for medical problems by: _____
(Signature of provider)

SRP CHECKLIST

Medical records: _____

Provider: _____

Team Leader: _____

Reviewer: _____