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MEMORANDUM FOR: Distribution List

Subject: Updated Procedures for Deployment Health Surveillance and Readiness

1. Force Health Protection (FHP) provides the conceptual framework for optimizing health readiness and protecting Service members from all health and environmental hazards associated with military service. A comprehensive health surveillance system is a critical component of FHP. Deployment health surveillance includes identifying the population at risk through personnel unit databases and pre- and post-deployment health assessments, recognizing and assessing potentially hazardous occupational and environmental health exposures and conditions, employing specific preventive countermeasures, monitoring of real time health outcomes, and timely reporting of disease and non-battle injury (DNBI) data to higher headquarters at least weekly. This memorandum provides standardized procedures for assessing health readiness and conducting health surveillance in support of all military deployments. Occupational and environmental health surveillance procedures have been added. General guidance is provided at Enclosure A and specific guidance is outlined in enclosures B through F.

2. Effective 1 March 2002, the health surveillance and readiness procedures described in this memorandum will be adhered to for all deployments (as defined at Enclosure A). This memorandum supersedes the health surveillance reporting procedures contained in the Joint Staff memorandum MCM-251-98,[1] and supports the implementation of DODD 6490.2,[2] DODI 6490.3,[3] and ASD(HA) policy memorandum.[4]

3. The Army Medical Surveillance Activity (AMSA) manages the Defense Medical Surveillance System (DMSS) deployment health data repository. All deployment health surveillance information will be forwarded to the DMSS for permanent archival and integration with DOD health information systems.

4. Tri-Service Reportable Events Guidelines and Case Definitions, blank pre- and post-deployment health assessment forms, DNBI reporting forms, and DMSS contact information are located on the AMSA web site at: http://amsa.army.mil. Questions may be directed to DSN 662-0471, or

commercial (202) 782-0471. The fax number is DSN 662-0612 or commercial (202) 782-0612.

5. The Joint Staff point of contacts are Major Brian Balough and Major Jeffrey Gillen, J-4, Medical Readiness Division, DSN 223-5101 or commercial (703) 693-5101. This document is also available electronically on the Joint Staff web site at http://www.dtic.mil/jcs/j4/divisions/mrd/.

For the Chairman of the Joint Chiefs of Staff:

JOHN P. ABIZAID
Lieutenant General, USA
Director, Joint Staff

Enclosure

References:

1 MCM-251-98, 4 December 1998, "Deployment Health Surveillance and Readiness"
2 DODD 6490.2, 30 August 1997, "Joint Medical Surveillance"
3 DODI 6490.3, 7 August 1997, "Implementation and Application of Joint Medical Surveillance for Deployments"
4 ASD-HA memorandum, 25 October 2001, "Updated Policy for Pre- and Post-Deployment Health Assessments and Blood Samples"

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ENCLOSURE A

GENERAL GUIDANCE

1. **Deployment**. For the purpose of joint health surveillance, a deployment is defined as a troop movement resulting from a Joint Chiefs of Staff (JCS)/combatant command deployment order for 30 continuous days or greater to a land-based location outside the United States. This deployment location does not have permanent US military medical treatment facilities (i.e., funded by the Defense Health Program) and may or may not be directly supported by deployed medical forces. Routine shipboard operations that are not anticipated to involve field operations ashore for over 30 continuous days are exempt from the mandatory requirements for pre- and post-deployment health assessments. Commanders are highly encouraged to accomplish deployed health surveillance activities for operations which may fall outside the current deployment definition. If the duration of deployment is uncertain, then the surveillance requirements described in this enclosure (pre- and post-deployment health assessments, health readiness, and DNBI reporting) will be met.

2. **Occupational and Environmental Health Surveillance**. Occupational and environmental health (OEH) hazards can seriously impact the mission and erode public confidence in the military's ability to protect US personnel. These hazards include exposures to harmful levels of environmental contaminants such as industrial toxic chemicals, chemical and biological warfare agents, and radiological and nuclear contaminants. "Harmful levels" include high-level exposures that result in immediate health effects and significant impacts to mission capabilities. Health hazards may also include low-level exposures that could result in delayed or long-term health effects that would not ordinarily have a significant impact on the mission.

a. Environmental Baseline Survey (EBS). Conducting an EBS of the deployed site should be accomplished as early as possible to meet force health protection mandates. The EBS identifies and quantifies occupational and environmental health and safety hazards that pose potential risks to US personnel at US Force locations. The EBS is intended to document occupational and environmental health hazards so they can be considered during operational planning as part of the operational Force Health Protection program. Technical guidance for conducting these surveys can be found in Army Field Manual FM 3-100.4 or the Air Force Air Mobility Command Environmental Baseline Survey protocol, at https://amc.scott.af.mil/sg/sgpb/readiness.html.

b. Industrial Hazard Assessments (IHA). The Armed Forces Medical Intelligence Center (AFMIC) has developed reports that identify potential local industrial operations and the hazards normally associated with those operations. IHAs should be utilized when pre-screening potential bed-down locations and during follow-on validation of the EBS when completing the OEH risk assessment. Preventive Medicine units use IHA information and EBS data integrated with the Operational Risk Management (ORM) process to identify OEH hazards, assess their risks, determine appropriate countermeasures, and develop effective risk communication techniques for commanders and deployed personnel.

3. **Disease Non-Battle Injury (DNBI)**. DNBI rates are an important tool at the unit level. Abnormal rates indicate a problem may exist which could negatively impact mission readiness and preventive medicine countermeasures need to be implemented. Historically, DNBI cost the field commander 99% of all personnel lost from deployed forces (validated during Operation DESERT STORM) and are largely preventable. The most valuable DNBI surveillance data is near real-time. Timely DNBI monitoring will permit: early casualty identification with potential adverse health trends, assessment of countermeasure effectiveness, and determination for enhanced countermeasures.

4. **Pre-deployment**. The supported combatant command, through deployment orders and separate instructions, will require the supporting combatant commands and Services to accomplish the following at the home station or processing station of the deploying military member. The supported combatant commands will incorporate the requirements of this memorandum into their deliberate and crisis action planning:

a. Theater-Wide Health Preparedness.

(1) Review infectious disease and environmental health risks for the area of operations. At a minimum, the infectious disease risk assessment, environmental health risk assessment, and disease occurrence worldwide regional updates produced by AFMIC should be reviewed. These resources are available through the intelligence component of the JS/combatant command staff (e.g., J-2, G-2, S-2). AFMIC maintains the Medical Environmental Disease Intelligence and Countermeasures (MEDIC) CD-ROM and up to date information on the following websites:

http://mic.afmic.detrick.army.mil/ (unclassified)

http://www.dia.smil.mil/intel/afmic/afmic.html (SECRET GCCS)

http://www.dia.ic.gov/intel/afmic/afmic.html (SCI JWICS)

(2) Establish requirements, allocate and assign appropriate medical resources to meet occupational and environmental health assessment and surveillance requirements, particularly in the earliest operational phases.

(3) Ensure commanders as well as all deployable personnel are trained in Service-specific operational risk management methods.

(4) Based on the threat, conduct studies at potential deployment sites to establish pre-deployment environmental health baseline conditions. Ensure these are integrated with related efforts conducted in accordance with Joint Publication 4-04, "Joint Doctrine for Civil Engineering Support."

(5) Complete risk assessments for all known health hazards in accordance with Joint Publication 5-00.2, "JTF Planning Guidance and Procedures," Joint Publication 2-01.3, "Joint Tactics, Techniques, and Procedures for Joint Intelligence Preparation of the Battlespace," and Service operational risk management guidance. Incorporate Health Risk Assessments into overall operational plans and specify requirements for risk control decisions by the appropriate level in the command.

(6) Incorporate risk management and surveillance recommendations into the Force Health Protection Appendix, Annex Q (Medical) of the deliberate or crisis action plan. Ensure these risks are reflected in the overall Operational Risk Summary evaluation. Communicate this information to subordinate units for inclusion into their unit-level planning. Medical threats should also be integrated into Annex B (Intelligence) as appropriate.

(7) Inform Service members of all known and perceived significant health threats, including endemic diseases; entomological hazards; nuclear, biological, or chemical (NBC) contaminants; toxic industrial materials (agricultural and industrial); deployment related stress; and climatic/environmental extremes (e.g., heat, cold, high altitude, wind blown sand and dirt).

(8) Employ proven preventive medicine countermeasures, to include, avoidance of hazardous locations when consistent with operational goals, and the use of appropriate personal protective measures and equipment.

(9) Conduct pre-deployment vulnerability assessment of preventive medicine concerns (validating AFMIC-identified medical threats). Assess vulnerabilities to local food and water sources, potential epidemiological threats, local medical capabilities, vector/pest threats, and hygiene of local billeting and public facilities. These assessments will provide the necessary information to determine the initial force protection strategies and resources required to mitigate risks to DOD personnel and assets.

b. Individual Medical Readiness. The DD Form 2766, "Adult Preventive and Chronic Care Flowsheet," is the DOD standard form in the medical record for

recording essential readiness indicators listed below. This will be the common location for minimum documentation by all Services, which may be supplemented by other forms such as Public Health Service Form PHS 731 and Service-specific forms. The DD Form 2766 will deploy with the individual. Complete individual medical readiness processing, including the following:

(1) Immunizations

(a) DOD Minimum Requirements. Must be current (as defined by most recent Advisory Committee on Immunization Practice vaccine specific schedules) in tetanus-diphtheria, influenza, hepatitis A, MR/MMR, and polio.

(b) Service-specific Requirements. Refer to AFJI 48-110, AR 40-562, BUMEDINST 6230.15, and CG COMDTINST M6230.4E, "Immunizations and Chemoprophylaxis," 1 November 1995.

(2) Deployment-specific medical countermeasures. Based upon the geographical location, the combatant command will determine the need for:

(a) Additional immunizations (e.g., anthrax, meningococcus, Japanese Encephalitis vaccine).

(b) Chemoprophylactic medications (e.g., Mefloquine, Chloroquine, Doxycycline)

(c) Other individual personal protective measures (such as insect repellent, bednetting, and uniform impregnation).

(3) Required occupational health personal protective equipment and training. For example: hearing protection, eye protection, NIOSH approved respiratory protection (including spare filter cartridges), protective clothing, and personal exposure dosimeters such as those that monitor chemical or radiation exposures.

(4) Individual Health Assessment. Conduct pre-deployment health assessments using the DD Form 2795 (Pre-deployment Health Assessment) and processing guidance at Enclosure B and ensure medical and dental requirements are current IAW Service policy, including:

(a) Mandatory occupational health examination and training requirements (e.g., respirator exams and fit testing).

(b) Dental Class I/II.

(c) No significant health conditions (e.g., P-4 profile, pregnancy).

(d) Collection of additional baseline biological samples as warranted by the deployment health threat.

(e) HIV testing IAW Service policy or the supported combatant command policy (serves dual purpose: HIV screening and pre-deployment serum sample).

(f) The most recent tuberculosis skin test (TST) results must be documented appropriately in the deployment health record. Currency (or periodicity) of TST is established by Service specific policies based upon analysis of Service unique risk factors. Thus, Service policies may permit more than a 24 month period to elapse between TSTs. For previous PPD converters handle IAW Service policy.

(g) DNA sample on file. To confirm the unit/individual status of DNA specimens on file, contact the DOD DNA Specimen Repository (voice 301-295-4379, fax 301-295-4380, or e-mail afrssir@afip.osd.mil).

(h) 90-day supply of prescription medications.

(i) Required medical equipment (glasses, protective mask inserts, hearing aids, dental orthodontic equipment, etc.).

(5) Medical Record. Create/Update the deployed medical record (DD Form 2766) with:

(a) Blood type.

(b) Medications/allergies.

(c) Special duty qualifications.

(d) Corrective lens prescription.

(e) Immunization record.

(f) DD Form 2795, Pre-deployment Health Assessment .

(g) Medical summary sheet identifying medical conditions (G6PD deficiency, sickle cell trait (HbS), etc.)

c. Pre-deployment Health Threat Brief. Provide information to deploying personnel identifying health threats and countermeasures to include applicable immunizations and other pre-exposure investigational new drugs such as pyridostigmine bromide.

5. **During Deployment**. The supported combatant command will provide guidance and support to component commands to:

a. Ensure subordinate medical activities conduct timely, standardized, comprehensive surveillance, risk assessments, and prevention of health hazards. These activities are based on the threat assessment and guidance provided in the Services' implementing instructions to DODI 6490.3, "Implementation and Application of Joint Medical Surveillance for Deployments," DODI 6055.1, "Department of Defense Safety and Occupational Health," to include DNBI (Enclosure C), reportable medical events (Enclosure D), and Occupational and Environmental Health Surveillance (Enclosure E).

b. Ensure DOD health surveillance requirements are met for reporting and archiving of health surveillance data and reports (DNBI, Reportable Medical Events, occupational and environmental health surveillance data, etc.). Ensure documentation in the individual medical records of all individual health treatment provided at all levels of care and any notable environmental and occupational exposures. Special attention is needed to ensure individual exposure records can be linked to individual health records.

c. Ensure environmental health risk assessments are continuously reviewed and updated throughout the deployment using data collected in theater. Ensure newly identified in-theater risks are assessed and incorporate operational risk management processes to provide commanders information for dissemination to military members. Collect data that are appropriate for medical record documentation. Significant newly identified risks should be communicated to all appropriate organizations, including the Defense Intelligence Agency (DIA) through AFMIC, Joint Task Forces (JTFs), combatant commands, Services, and Service Occupational and Environmental Health Centers.

d. The JTF/combatant command personnel readiness unit will ensure the Defense Manpower Data Center (DMDC) is provided theater-wide rosters of all deployed personnel, their unit assignments (company-sized or equivalent) and the unit's geographic locations IAW the reporting requirements of DODI 1336.5, "Automated Extract of Active Duty Military Personnel Records," Enclosure 5, including attachment. Accurate personnel deployment rosters are required to assess the relative significance of medical disease/injury in terms of the rate of occurrence among the deployed population. Without the means to identify the locations of deployed personnel it will not be possible to accurately determine potential exposures to hazardous materials and agents.

e. Conduct pest control operations using the integrated pest management (IPM) program described in DODI 4150.7, "DOD Pest Management Program," 22 April 1996, and current Armed Forces Pest Management Board guidance (Technical Information Memorandum No. 1, "AFPMB Publications," January 2001). Document the types, concentrations, amounts, application methods, dates and times, locations, and the personnel potentially exposed to the

hazardous substances IAW OASD(AT&L) memorandum, dated February 1, 1999.

6. **Post-Deployment**.

a. The combatant command or Service components will provide guidance and support to ensure the following are accomplished in-theater prior to re-deployment:

(1) Conduct timely post-deployment health assessments using DD Form 2796 and processing guidance at Enclosure F.

(2) Identify Service members in need of medical evaluation upon return to home/processing station based on review of medical treatment received in theater, the post-deployment health assessment form, and other pertinent health surveillance data. Reserve component members in need of a more detailed medical evaluation or treatment shall complete DD Form (Report of Medical Assessment) and, with the member's consent, be retained on active duty pending resolution of their medical conditions as provided in section 12301 of Title 10, United States Code, and implemented in ASD(RA) memorandum, 26 May 2000, "Authority to Call Reserve Component Members to Active Duty for Medical Purposes."

(3) Conduct medical debriefing with re-deploying Service members on all significant health events, exposures, and concerns (also identified on post-deployment health assessments). Ensure these events and exposures are documented in individual Service member's health records. Medical debriefing ideally occurs within 5 days prior to departure from theater, but may be conducted within 5 days upon return to CONUS/home station.

(4) Ensure significant occupational and environmental health related events/exposures are included in operational After Action Reports (AARs). This shall include any disease outbreaks, location of industrial sources, contaminated sites (hazardous materials/wastes, NBC, other), presence of disease vectors, and other operational factors that affected the overall health status (acute, chronic, or latent effects) of the deployed Service members. Ensure AARs are provided to the intelligence community (including AFMIC) and Service centers for lessons learned to be incorporated into future operational planning. Ensure all occupational and environmental health data is forwarded for analysis and archival in accordance with the procedures in Enclosure E.

(5) Develop and forward force health protection lessons learned to the Joint Uniform Lessons Learned System (JULLS).

b. The Services or supporting combatant commands must accomplish the following at the home station or processing station of the re-deploying service member:

(1) For deployments to high TB threat areas or operations such as those involving close contact with large refugee populations, conduct TB screening between 3 and 12 months after redeployment IAW Service-specific requirements. For deployments to non-high TB threat areas, conduct TB screening IAW Service-specific policy. Interpretation of the Tuberculin Skin Test (TST) results should be IAW Service policy.

(2) Collect, when indicated by Service policy, a serum sample for HIV testing and storage in the serum repository. Collect additional biological samples as warranted by the events occurring in theater or post-deployment health assessment responses and evaluations.

(3) Conduct additional health assessments and/or health debriefings when indicated.

c. Service members returning from a theater with deployment related health concerns will be evaluated using the Post-Deployment Health Clinical Practice Guideline. Health care providers should consult the DOD Post-Deployment Health web site, www.pdhealth.mil, for further information on the clinical practice guidelines.

ENCLOSURE B

PRE-DEPLOYMENT HEALTH ASSESSMENT FORM (DD Form 2795) PROCESSING GUIDANCE

1. Service members must complete or re-validate the health assessment form at their home station or processing station within 30 days prior to their deployment. Internet forms may be locally reproduced. Blank forms are available for download from the Army Medical Surveillance Activity (AMSA) at the following web-site: http://amsa.army.mil. Forms should be printed on both sides in a head-to-head orientation. Forms should not be stapled or treated with chemicals.

2. The form must be administered and then immediately reviewed by a health care provider. The provider can be a medical technician, medic or corpsman for administering and initially reviewing the questionnaire. However, positive responses to questions 2-4 and 7-8 must be referred to a physician, physician's assistant, nurse, or independent duty medical technician.

3. The original of the completed form must be placed in the Service member's permanent medical record. Copies will be immediately forwarded to the AMSA, Building T-20, Room 213 (ATTN: Deployment Forms), 6900 Georgia Avenue, N.W., Washington, D.C., 20307-5001, DSN 662-0471 or commercial (202) 782-0471.

4. AMSA receives pre-deployment health assessments, performs data entry, and integrates the data into the Defense Medical Surveillance System (DMSS). AMSA has the capability to provide the Joint Staff, combatant commands, and the Services with periodic trend analysis reports on the completed DD Forms 2795.

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PRE-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health before possible deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Deploying Unit

Today's Date (dd/mm/yyyy) / /

Social Security Number - -

DOB (dd/mm/yyyy) / /

Gender

- ○ Male
- ○ Female

Service Branch

- ○ Air Force
- ○ Army
- ○ Coast Guard
- ○ Marine Corps
- ○ Navy
- ○ Other

Component

- ○ Active Duty
- ○ National Guard
- ○ Reserves
- ○ Civilian Government Employee

Pay Grade

- ○ E1
- ○ E2
- ○ E3
- ○ E4
- ○ E5
- ○ E6
- ○ E7
- ○ E8
- ○ E9
- ○ O1
- ○ O2
- ○ O3
- ○ O4
- ○ O5
- ○ O6
- ○ O7
- ○ O8
- ○ O9
- ○ O10
- ○ W1
- ○ W2
- ○ W3
- ○ W4
- ○ W5
- ○ Other

Location of Operation

- ○ Europe
- ○ SW Asia
- ○ SE Asia
- ○ Asia (Other)
- ○ South America
- ○ Australia
- ○ Africa
- ○ Central America
- ○ Unknown

Deployment Location (IF KNOWN) (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
○	○	○	Medical threat briefing completed
○	○	○	Medical information sheet distributed
○	○	○	Serum for HIV drawn within 12 months
○	○	○	Immunizations current
○	○	○	PPD screening within 24 months

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PLEASE FILL IN SOCIAL SECURITY # ___ - ___ - ____

Health Assessment

1. Would you say your health in general is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
2. Do you have any medical or dental problems? ○ Yes ○ No
3. Are you currently on a profile, or light duty, or are you undergoing a medical board? ○ Yes ○ No
4. Are you pregnant? (FEMALES ONLY) ○ Don't Know ○ Yes ○ No
5. Do you have a 90-day supply of your prescription medication or birth control pills? ○ N/A ○ Yes ○ No
6. Do you have two pairs of prescription glasses (if worn) and any other personal medical equipment? ○ N/A ○ Yes ○ No
7. During the past year, have you sought counseling or care for your mental health? ○ Yes ○ No
8. Do you currently have any questions or concerns about your health? ○ Yes ○ No

Please list your concerns: _____

_____

Service Member Signature

I certify that responses on this form are true.

Pre-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

- ○ None
- ○ Cardiac
- ○ Combat / Operational Stress Reaction
- ○ Dental
- ○ Dermatologic
- ○ ENT
- ○ Eye
- ○ Family Problems
- ○ Fatigue, Malaise, Multisystem complaint
- ○ GI
- ○ GU
- ○ GYN
- ○ Mental Health
- ○ Neurologic
- ○ Orthopedic
- ○ Pregnancy
- ○ Pulmonary
- ○ Other _____

FINAL MEDICAL DISPOSITION:

○ **Deployable** ○ **Not Deployable**

Comments: (If not deployable, explain)

_____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp:

Date (dd/mm/yyyy) ___ / ___ / ____

End of Health Review

ENCLOSURE C

WEEKLY DISEASE AND NON-BATTLE INJURY (DNBI) REPORT INSTRUCTIONS

1. Disease and Non-Battle Injury Rates - The Vital Signs of the Unit

a. Disease and non-battle injury (DNBI) rates are an important tool at the unit level. The DNBI report summarizes the weekly DNBI data rates and provides baseline rates for comparison. Abnormal rates indicate a problem exists which could negatively impact readiness and indicates preventive medicine countermeasures need to be implemented. Unit data must be reported weekly (ending Saturday 2359 hrs local) via command channels through the JTF Surgeon to the Combatant Command Surgeon. Additionally, DNBI data must be simultaneously reported to the Service Surveillance Centers for further analysis and to the DMSS for repository purposes. Service Health Surveillance Centers (AFIERA, NEPMU, and CHPPM) further analyze DNBI data, identifying adverse trend and reporting health threat anomalies to the JTF/Combatant Command Surgeon. The supported Combatant Command Surgeon will release DNBI reports to the Joint Staff and the Services/components when significant medical threats are encountered.

b. The DNBI report is based on unit logs, which must record at a minimum the following information on every patient encounter. Some information required for record as part of the DNBI data collection (e.g. name, SSN, gender, unit, etc.) is not required for completion of the "Weekly DNBI Report". The purpose of collecting this information is to allow local medical authorities to quickly review pertinent data that describes the occurrence of medical events. This is particularly useful for investigation of outbreaks or other medical problems, which may occur during the deployment. Information sources for the DNBI report include the sick call log, electronic patient record, and accident reports:

(1) Patient's name, SSN, gender, unit, unit identification code (UIC), and duty location.

(2) Type of visit - new, follow-up, or administrative.

(3) Primary complaint.

(4) Final diagnosis.

(5) Injuries, a classification into recreation/sports, motor vehicle accident (MVA), work/training, or other.

(6) Final disposition into one of the following categories:

- Full duty.

- Light duty (number of days).
- Sick in quarters (number of days).
- MTF in-patient admissions (number of days).

(7) DNBI category (case definitions provided at the end of this enclosure).

c. Sick call logbooks, electronic patient records, and other records of raw data compiled to create the DNBI report must be retained by the medical unit at the conclusion of the deployment for at least one-year. Medical units will forward copies of all deployment sick call logs annually to DMSS for archiving.

2. DNBI report instructions.

a. Record the administrative data in the spaces provided at the top of the "Weekly DNBI Report" form, located at the end of this enclosure. Obtain average troop strength for the reporting period from the S-1/J-1.

b. Review the sick call log and add up the total number of new cases (excluding follow-ups) seen during the week in each DNBI category. Fill in the appropriate block. Add up the total DNBI and record the number in the space provided.

c. To calculate DNBI rates, divide the total number of patients seen in each category by the average troop strength, and multiply by 100. For the gynecologic category, the FEMALE troop strength must be used to calculate the rate, not the total troop strength. Remember to calculate an overall DNBI total rate.

> **Example**. If there were 20 dermatological cases this week in 500 troops, the DNBI rate (percent) for dermatological cases would be calculated as follows:

$$DNBI\ (\%) = \left(\frac{\#Patients}{\#Troops} \right) \times 100$$

$$DNBI_{derm}(\%) = \left(\frac{20}{500} \right) \times 100$$

$$DNBI_{derm}(\%) = (0.04) \times 100$$

$$DNBI_{derm}(\%) = 4\%$$

d. Next, add up the total number of estimated light duty days, lost workdays (total of sick-in-quarters days plus in-patient admission days), and MTF in-patient admissions in each category, and fill in the appropriate block.

e. Compare calculated rates for each category with the suggested reference rate for that category (comment is required under the section "Problems Identified - Corrective Actions" for all categories where rates are above the suggested reference rate). When comparing rates, keep the following information in mind:

(1) The suggested reference rates are only approximate and should be used as a rough guide only. The combatant command or JTF Surgeon may modify the "Suggested Reference Rates" based upon theater/deployment specific trends. Establishing statistical confidence levels of 2 and 3 standard deviations is desirable when sufficient DNBI data has been collected.

(2) Exceeding a rate by 0.1 percent is not necessarily an indication of a significant problem. Rates between 2 and 3 standard deviations should heighten surveillance. Rates exceeding 3 standard deviations indicate that there is a health problem requiring urgent attention, possible intervention, and reporting to the JTF/Combatant Command Surgeon.

(3) The individual suggested reference rates are not intended to add up to the total DNBI suggested reference rate. An individual category could have a high rate without causing the total rate to exceed the reference rate - attention to the individual category is appropriate and necessary in this situation. Alternatively, the total DNBI rate could be high without causing individual categories to exceed their reference rates – attention to systemic problems causing general sick call visits to rise is appropriate and necessary in this situation.

(4) Use common sense in interpreting the DNBI rates. Track DNBI rates over time and compare current DNBI rates with your unit's past DNBI rates for comparable situations.

3. Report weekly DNBI data to the unit commander and to medical personnel at higher echelons (as noted in the first paragraph of these instructions). The combatant command is the releasing authority for all reportable DNBI outcomes. Service centers will coordinate with theater medical surveillance teams, if deployed, or JTF surgeon when adverse trends occur. The theater surveillance teams will augment organic preventive medicine units to investigate the cause of the adverse DNBI incident.

CASE DEFINITIONS

Notes:

1. Count only the initial visit. Do not count follow-up visits.

2. All initial sick call visits should be placed in a category. Some patients with multiple ailments may need to be counted in multiple categories.

3. If in doubt about which category, make the best selection.

4. Estimate days of light duty, lost workdays, or admissions resulting from initial visits.

Combat/Operational Stress Reactions – Includes acute debilitating mental, behavioral, or somatic symptoms thought to be caused by operational or combat stressors, that are not adequately explained by physical disease, injury, or a preexisting mental disorder, and that can be managed with reassurance, rest, physical replenishment, and activities that restore confidence.

Dermatological - Diseases of the skin and subcutaneous tissue, including heat rash, fungal infection, cellulitis, impetigo, contact dermatitis, blisters, ingrown toenails, unspecified dermatitis, etc. Includes sunburn.

Gastrointestinal, Infectious - All diagnoses consistent with infection of the intestinal tract. Includes any type of diarrhea, gastroenteritis, "stomach flu," nausea/vomiting, hepatitis, etc. Does NOT include non-infectious intestinal diagnoses such as hemorrhoids, ulcers, etc.

Gynecological - Menstrual abnormalities, vaginitis, pelvic inflammatory disease, or other conditions related to the female reproductive system. Does not include pregnancy.

Heat/Cold Injuries - Climatic injuries, including heat stroke, heat exhaustion, heat cramps, dehydration, hypothermia, frostbite, trench foot, immersion foot, and chilblain.

Injuries, Recreational/Sports - Any injury occurring as a direct consequence of the pursuit of personal and/or group fitness, excluding formal training.

Injuries, Motor Vehicle Accidents - Any injury occurring as a direct consequence of a motor vehicle accident.

Injury, Work/Training - Any injury occurring as a direct consequence of military operations/duties or of an activity carried out as part of formal military training, to include organized runs and physical fitness programs.

Injury, Other - Any injury not included in the previously defined injury categories.

Ophthalmologic - Any acute diagnosis involving the eye, including pink-eye, conjunctivitis, sty, corneal abrasion, foreign body, vision problems, etc. Does not include routine referral for glasses (non-acute).

Psychiatric, Mental Disorders – Debilitating mental, behavioral or somatic symptoms that meet diagnostic criteria for or have been previously diagnosed as a psychiatric/mental disorder. Does NOT include symptoms due to identified physical disease or injury, or symptoms better explained as a transient combat/operational stress reaction.

Respiratory - Any diagnosis of the: lower respiratory tract, such as bronchitis, pneumonia, emphysema, reactive airway disease, and pleurisy; or the upper respiratory tract, such as "common cold," laryngitis, tonsillitis, tracheitis, otitis and sinusitis.

Sexually Transmitted Diseases - All sexually transmitted infections including chlamydia, HIV, gonorrhea, syphilis, herpes, chancroid, and venereal warts.

Fever, Unexplained - Temperature of 100.5^{0}F or greater for 24 hours, or history of chills and fever without a clear diagnosis (this is a screening category for many tropical diseases such as malaria, dengue fever, and typhoid fever). Such fever cannot be explained by other inflammatory/infectious processes such as respiratory infections, heat, and overexertion.

All Other, Medical/Surgical - Any medical or surgical condition not fitting into any category above.

Dental - Any disease of the teeth and oral cavity, such as periodontal and gingival disorders, caries, and mandible anomalies.

Miscellaneous/Administration/Follow-up - All other visits to the treatment facility not fitting one of the above categories, such as profile renewals, pregnancy, immunizations, prescription refills, and physical exams or laboratory tests for administrative purposes.

Definable - An additional category established for a specific deployment based upon public health concerns (e.g., malaria, dengue, airborne/HALO injuries, etc.).

WEEKLY DNBI REPORT

Unit/Command: _____ **Troop Strength:** _____

Dates Covered: _____ **(Sunday 0001) Through** _____ **(Saturday 2359)**

Individual Preparing Report: _____

Phone: _____ **E-Mail:** _____

CATEGORY	INITIAL VISITS	RATE	SUGGESTED REFERENCE RATE	DAYS OF LIGHT DUTY	LOST WORK DAYS	ADMITS
Combat/Operational Stress Reactions			0.1%			
Dermatologic			0.5%			
GI, Infectious			0.5%			
Gynecologic			0.5%			
Heat/Cold			0.5%			
Injury, Recreational/Sports			1.0%			
Injury, MVA			1.0%			
Injury, Work/Training			1.0%			
Injury, Other			1.0%			
Ophthalomologic			0.1%			
Psychiatric, Mental Disorders			0.1%			
Respiratory			0.4%			
STDs			0.5%			
Fever, Unexplained			0.0%			
All Other, Medical/Surgical						
TOTAL DNBI			4.0%			

Dental		XXXXXX				
Misc/Admin/ Follow-up		XXXXXX				
Definable						
Definable						

Problems Identified: _____ **Corrective Actions:** _____

_____ _____

_____ _____

DNBI Reporting Form for Joint Deployments

JOINT STAFF APPROVED – NOVEMBER 1998

ENCLOSURE D

TRI-SERVICE REPORTABLE MEDICAL EVENT LIST

Condition	ICD-9 code	Condition	ICD-9 code
1. Amebiasis	006	36. Listeriosos	027.0
2. Anthrax	022	37. Lyme Disease	088.81
3. Biological Warfare Agent Exposure	E997.1	38. Malaria (all)	
4. Botulism	005.1	a) Malaria, Falciparum	084.0
5. Brucellosis	023	b) Malaria, Vivax	084.1
6. Campylobacter	008.43	c) Malaria, Malariae	084.2
7. Carbon Monoxide Poisoning	986	d) Malaria, Ovale	084.3
8. Chemical Agent Exposure	989	e) Malaria, Unspecified	084.6
9. Chlamydia	099.41	39. Measles	055
10. Cholera	001	40. Meningococcal disease	
11. Coccidioidomycosis	114	a) Meningitis	036.0
12. Cold Weather Injury (All)		b) Septicemia	036.2
a) CWI, Frostbite	991.3	41. Mumps	072
b) CWI, Hypothermia	991.6	42. Pertussis	033
c) CWI, Immersion Type	991.4	43. Plague	020
d) CWI, Unspecified	991.9	44. Pneumococcal pneumonia	481
13. Cryptosporidiosis	007.4	45. Poliomyelitis	045
14. Cyclosporiasis	136.8	46. Q fever	083.0
15. Dengue Fever	061	47. Rabies, Human	071
16. Diphtheria	032	48. Relapsing Fever	087
17. E. Coli 0157:H7	008.04	49. Rheumatic Fever, Acute	390
18. Ehrlichiosis	083.8	50. Rift Valley Fever	066.3
19. Encephalitis	062	51. Rocky Mountain Spotted Fever	082.0
20. Filariasis	125	52. Rubella	056
21. Giardiasis	007.1	53. Salmonellosis	003
22. Gonorrhea	098	54. Schistosomiasis	120
23. H. Influenzae, Invasive	038.41	55. Shigellosis	004
24. Hantavirus Infection	079.81	56. Smallpox	050
25. Heat Injuries		57. Streptococcus, Group A, Invasive	038.0
a) Heat Exhaustion	992.3	58. Syphilis (All)	
b) Heat Stroke	992.0	a) Syphilis, Primary/Secondary	091
26. Hemorrhagic fever	065	b) Syphilis, Latent	096
27. Hepatitis A	070.1	c) Syphilis, Tertiary	095
28. Hepatitis B	070.3	d) Syphilis, Congenital	090
29. Hepatitis C	070.51	59. Tetanus	037
30. Influenza	487	60. Toxic Shock Syndrome	785.59
31. Lead poisoning	984	61. Trichinosis	124
32. Legionellosis	482.8	62. Trypanosomiasis	086
33. Leishmaniasis (all)		63. Tuberculosis, Pulmonary	011
a) Leishmaniasis, Cutaneous	085.4	64. Tularemia	021
b) Leishmaniasis, Mucocutaneous	085.5	65. Typhoid Fever	002
c) Leishmaniasis, Visceral	085.0	66. Typhus fever	080
d) Leishmaniasis, Unspecified	085.9	67. Urethritis, Non-Gonococcal	099.40
34. Leprosy	030	68. Vaccine, Adverse Event	979.9
35. Leptospirosis	100	69. Varicella, Active Duty Only	052
		70. Yellow Fever	060

NOTES:
1) This list represents minimum reportable events and can be supplemented by the Combatant Command, as necessary.
2) Tri-Service Reportable Events Guidelines and Case Definitions are available at: http://amsa.army.mil under "Documents" heading.

ENCLOSURE E

OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE

1. Introduction. Traditionally, deployment medical risk analysis and assessments have concentrated on the historically proven threats posed by infectious disease as a major cause of Disease and Non-Battle Injury (DNBI). Recent studies conducted by AFMIC, "DIA Report – Medical Intelligence Assessment of Deployment Environmental Health Risks," Jan 99, DI 1816-8-99, considered the risks of exposure to chemical and physical hazards from environmental contamination as an increasingly important element of force health protection, whether as the result of an accidental release, existing contamination or a directed action by an adversary.

2. Occupational and Environmental Health (OEH) Risk Assessment Process.

a. Background. Occupational and environmental health hazards can seriously impact the mission and erode public confidence in the military's ability to protect US personnel. These hazards include exposures to harmful levels of environmental contaminants such as toxic chemicals, radiation, or biological agents. "Harmful levels" include high-level exposures that result in immediate health effects and significant impacts to mission capabilities. Health hazards may also include low-level exposures that could result in delayed or long-term health effects that would not ordinarily have a significant impact on the mission. Commanders must utilize OEH surveillance to identify these hazards, assess the potential risks, determine appropriate risk control measures, and communicate these risks to their forces via Operational Risk Management (ORM) processes.

b. ORM as outlined in Service Doctrine, is a process for identifying, assessing, and controlling risks from operational hazards, including OEH hazards. Risk is determined by estimating the probability and severity of a potential adverse impact that may result from hazards due to the presence of an adversary or some other hazardous condition (i.e., such as environmental contamination). Risks range from low through extremely high. Leaders seek to mitigate risk by evaluating hazards and implementing ORM options during operational planning. When applied by medical personnel the ORM process allows planners to include the assessment of the severity of hazards, characterize the risks in the context of the proposed operation, and then effectively communicate the risk assessments and appropriate control measure options to the Commander. Commanders then make informed decisions by balancing the OEH risks and other operational risks with mission requirements.

c. Risk Assessment Process. The matrix below summarizes the ORM process. It is a qualitative tool, but the process of categorizing the health effects is largely quantitative. The quantitative parameters include, but are not

limited to: dose, exposure time, route of exposure (skin, inhalation, ingestion, etc.), and comparisons to established acute and chronic toxic thresholds.

RISK ASSESSMENT MATRIX

HAZARD SEVERITY	HAZARD PROBABILITY				
	Frequent (A)	Likely (B)	Occasional (C)	Seldom (D)	Unlikely (E)
Catastrophic (I)	Extremely High	Extremely High	High	High	Moderate
Critical (II)	Extremely High	High	High	Moderate	Low
Marginal (III)	High	Moderate	Moderate	Low	Low
Negligible (IV)	Moderate	Low	Low	Low	Low
	RISK ESTIMATE				

(1) Hazard Probability (horizontal-axis). The likelihood of a Service member encountering a hazard. Effective employment of mitigation strategies, such as personal protective equipment or avoidance, usually shifts the Hazard Probability to the right, thereby decreasing health risk.

(2) Hazard Severity (vertical-axis). A measure of the impact of the interaction of the hazard with the human, this relates biochemical and/or physiological side effects (short and long term) to health outcome.

(3) Risk Estimate. The body of the matrix defines the risk estimate ranging from extremely high to low.

d. Risk Assessment Components. The OEH Risk Assessments should include an evaluation of occupational health exposures from deployed operational tasks and ambient environmental health exposures: air, soil, potable and non-potable waters, ionizing and non-ionizing radiological sources, vector borne threats and other physical hazards. OEH hazards may be present as contamination from historical site usage, battle damage, stored stockpiles, and adjacent commercial or residential sites. The OEH Risk Assessment requires initial and continued surveillance of the following criteria components:

(1) Ambient Air. The assessment should monitor for volatile organic compounds (VOCs), semi-volatile organic compounds (SVOCs), polynuclear aromatic hydrocarbons (PAHs), pesticides, metals, radiation, total and respirable particulate matter (PM), and combustion-related pollutants such as carbon monoxide, sulfur dioxide, ozone, and nitrogen oxides. Other contaminants may include: chemical warfare agents, military smokes and obscurants, riot control agents, and other toxic industrial materials expected to be present in the area of operations.

(2) Soil. The assessment should monitor for heavy metals, pesticides, herbicides, VOCs, SVOCs, explosives, and radiation. Additional samples should be collected following hazardous material, petroleum, oil and lubricants (POL) spills and prior to closure of the site to document final conditions. Data to support this assessment may be available from the Environmental Baseline Surveys (see paragraph 3a below).

(3) Water. The assessment should include an evaluation for chemical, metal, biological, and radiological content of potable and non-potable waters IAW the DOD Tri-Service Field Water Guidance (Sanitary Control and Surveillance of Field Water Supplies (AFOSH 48-7/NAVMED P-5010-9/TBMED 577)). This criteria includes water-vulnerability assessments identifying difficulties in maintaining a potable water source, essential non-potable water availability needs (e.g., sanitary and fire fighting) and vulnerability to sabotage or process upsets. Identify and evaluate proposed wastewater (including greywater) collection and treatment or disposal systems.

(4) Radiological Surveys. The assessment should include an evaluation of the need to survey sites for background radiation, ionizing and non-ionizing radiation sources, and radiological contamination. If battle damage is present, perform a rapid hazard assessment for radiation sources and radioactive contamination. Acceptable exposure levels should be established for the theater according to NATO STANAG 2473.

(5) Noise. An environmental noise assessment should be performed if industrial or other noise-producing hazards exist.

(6) Occupational Health. Assess occupational hazards and determine whether control measures are in-place and adequate. Recommend appropriate countermeasures, document occupational health exposures, and report results to immediate supervisors and commanders.

e. Record keeping and Reporting Requirements.

(1) Document the following data for each sample collected : a unique sample number/designation, sample location (established with military GPS, if available), date and time the sample was taken, sample type (e.g., bulk, grab, composite, blank), sample media (air, water, soil), sampling method, sample

site conditions, any immediate corrective actions required, sampling personnel information, and laboratory information.

(2) As operations allow, report sample results and risk assessments as quickly as possible to local medical units and JTF Surgeon in accordance with theater policy. Summary reports will be sent from the JTF Surgeon to the Combatant Command Surgeon. Copies of all data, data summaries, final reports, and investigations will be forwarded, at least quarterly, from the JTF Surgeon to the Combatant Command Surgeon and to the Deployment Environmental Surveillance Program (DESP), US Army Center For Health Promotion and Preventive Medicine, ATTN: MCHB-TS-EES, 5158 Blackhawk Road, Aberdeen Proving Grounds, MD 21010-5422, 1-800-222-9698, DSN 584-6096 or commercial (410) 436-6096. The DESP will provide advanced technical support and coordinate data archival with the DMSS.

(3) Documentation of negative results is just as critical for future analysis to identify the lack of an environmental or occupational hazard exposures. Therefore, it is extremely important that all results reported per above instructions.

3. Pre-deployment. The supported and supporting combatant commands will:

a. Develop and maintain an Environmental Baseline Survey (EBS) utilizing Industrial Hazard Assessments (IHAs) (see Enclosure A, paragraph 2b) for all pre-selected critical operating locations (aerial ports, seaports, and key land areas) identified during the deliberate planning stage in the supported command's operation plans. IHAs utilize current intelligence information to assist postulating health risks that may have potential mission impact.

b. Establish countermeasures or risk control actions to decrease specific OEH risks identified in the IHA as part of the overall operational planning process (i.e., Intelligence Preparation of the Battlefield).

c. Identify the medical resources required to validate the IHA and to conduct follow-on OEH risk assessment and EBS operations during all phases of the deployment. Incorporate these requirements into operational staffing requirements.

d. Establish a risk communication plan addressing the OEH risks in understandable terms for the commanders, operational planners, and deploying personnel.

e. Establish record keeping and archiving procedures to provide OEH data to assist in post-deployment health assessments and evaluations of OEH risk management processes.

f. Incorporate the above information into the Force Health Protection appendix to Annex Q to the Operations Plan.

4. During Deployment. Based on the pre-deployment OEH risk assessment conducted during the planning process, the combatant commands will develop and maintain an appropriate OEH surveillance and monitoring program for the deployment. If the resource requirements are beyond the capabilities of organic preventive medicine assets, the JTF/Combatant Command Surgeon should request the required capability/expertise and oversee the assignment of technically-specialized unit(s) or detachment(s) to perform these functions in theater.

a. Preventive medicine personnel will assess the need to collect on-site samples. Unless adequate, pre-existing data is available, preventive medicine personnel will employ appropriate field sampling, laboratory and analytical techniques to conduct these assessments in the minimal time required to accurately assess the OEH risk.

(1) Potential "High" and "Extremely High" risk situations require rapid health risk assessment using real/near real time on-site methods. On site methods usually require confirmatory laboratory analysis.

(2) Potential "Moderate" risk situations may be assessed by collection of samples for off-site analysis, with rear area laboratory support as required.

(3) Potential "Low" risk situations may be assessed off-site, using mathematical models to assign risks, with sampling and rear area laboratory support as operational resources allow.

b. Assistance regarding potential hazard severity, hazard probability, assessment techniques, and rear area laboratory support can be obtained from the Service Health Surveillance Centers.

5. Post-deployment. The combatant and supporting commands will:

a. Document occupational and environmental health assessments. Forward assessments to the DMSS archive.

b. Ensure all sample results and risk assessments have been reported in accordance with the instructions listed in Enclosure A.

c. Document appropriate medical follow-up to address occupational and environmental health concerns related to review of DD Form 2796 responses.

d. Develop any OEH Surveillance Lessons Learned and forward IAW Service-specific lessons learned guidance with a copy to the Service Health Surveillance Centers and DMSS.

ENCLOSURE F

POST-DEPLOYMENT HEALTH ASSESSMENT FORM (DD Form 2796) PROCESSING GUIDANCE

1. Service members must complete the health assessment form in theater, within 5 days upon redeployment back to their home station. Internet forms may be locally reproduced. Blank forms are available for download from the Army Medical Surveillance Activity (AMSA) at the following web-site: http://amsa.army.mil. Forms should be printed on both sides in a head-to-head orientation. Forms should not be stapled or treated with chemicals.

2. The DD form 2796 must be administered and immediately reviewed by a health care provider. The provider can be a medic or corpsman for administering and initially reviewing the questionnaire. Positive responses must be immediately referred to a physician, physician's assistant, nurse, or independent duty medical technician for further review of their deployment health records (DD forms 2766, 2795, and 2796).

3. The original completed form must be placed in the Service member's permanent medical record or in the deployed medical record for transfer to their permanent medical record upon redeployment to their home station. Copies will be immediately forwarded to the AMSA, Building T-20, Room 213 (ATTN: Deployment Forms), 6900 Georgia Avenue, N.W., Washington, D.C., 20307-5001, DSN 662-0471 or commercial (202) 782-0471.

4. AMSA receives post-deployment health assessments, performs data entry, and integrates the data into the Defense Medical Surveillance System (DMSS). AMSA has the capability to provide the Joint Staff, combatant command, and the Services with periodic trend analysis reports on the completed DD Forms 2796.

POST-DEPLOYMENT Health Assessment

33348

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Deployed Unit

Today's Date (dd/mm/yyyy) / /

Social Security Number - -

DOB (dd/mm/yyyy) / /

Date of arrival in theater (dd/mm/yyyy) / /

Date of departure from theater (dd/mm/yyyy) / /

Gender

- ○ Male
- ○ Female

Service Branch

- ○ Air Force
- ○ Army
- ○ Coast Guard
- ○ Marine Corps
- ○ Navy
- ○ Other

Component

- ○ Active Duty
- ○ National Guard
- ○ Reserves
- ○ Civilian Government Employee

Pay Grade

- ○ E1
- ○ E2
- ○ E3
- ○ E4
- ○ E5
- ○ E6
- ○ E7
- ○ E8
- ○ E9
- ○ O1
- ○ O2
- ○ O3
- ○ O4
- ○ O5
- ○ O6
- ○ O7
- ○ O8
- ○ O9
- ○ O10
- ○ W1
- ○ W2
- ○ W3
- ○ W4
- ○ W5
- ○ Other

Location of Operation

- ○ Europe
- ○ SW Asia
- ○ SE Asia
- ○ Asia (Other)
- ○ South America
- ○ Australia
- ○ Africa
- ○ Central America
- ○ Unknown

Deployment Location (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
○	○	○	Medical threat debriefing completed
○	○	○	Medical information sheet distributed
○	○	○	Post-Deployment serum specimen collected, if required

33348

PLEASE FILL IN SOCIAL SECURITY # ☐☐☐ - ☐☐ - ☐☐☐☐

Health Assessment

1. Would you say your health in general is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
2. Do you have any unresolved medical or dental problems that developed during this deployment? ○ Yes ○ No
3. Are you currently on a profile or light duty? ○ Yes ○ No
4. During this deployment have you sought, or intend to seek, counseling or care for your mental health? ○ Yes ○ No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health? ○ Yes ○ No

   Please list your concerns: _____

   _____

6. Do you currently have any questions or concerns about your health? ○ Yes ○ No

   Please list your concerns: _____

   _____

Service Member Signature

I certify that responses on this form are true. ☐

Post-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

- ○ None
- ○ Cardiac
- ○ Combat / Operational Stress Reaction
- ○ Dental
- ○ Dermatologic
- ○ ENT
- ○ Eye
- ○ Family Problems
- ○ Fatigue, Malaise, Multisystem complaint
- ○ GI
- ○ GU
- ○ GYN
- ○ Mental Health
- ○ Neurologic
- ○ Orthopedic
- ○ Pregnancy
- ○ Pulmonary
- ○ Other _____

EXPOSURE CONCERNS (During deployment)

Provider see questions 5&6 on this form

- ○ Environmental
- ○ Occupational
- ○ Combat or mission related
- ○ None

Comments: _____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp:

☐

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

End of Health Review