ARMY REGULATION
No. 40–2

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MEDICAL SERVICES

ARMY MEDICAL TREATMENT FACILITIES GENERAL ADMINISTRATION

Effective 1 April 1978

This is a complete revision of AR 40–2. It adds instructions formerly contained in section II, chapter 4, AR 340–1 for requesting research in medical records and routing requests for medical records; provides guidance on therapeutic dietary supplements and use of blood serum; makes procedural changes in maintenance of the Patients' Trust Fund; provides instruction on use of DA Form 2005, Privacy Act Statement—Health Care Records; updates terminal digit filing section to allow for alphabetical and terminal digit file for treatment record; updates instruction for hospital food service and pharmacy management; adds complete section on Consumer Health Program; and updates addresses, references and terminology. Local limited supplementation of this regulation is permitted but it is not required. If supplements are issued, Army staff agencies and major Army commands will furnish one copy of each to HQDA (DASG-HCP), Washington, DC 20310; other commands will furnish one copy of each to the next higher headquarters.

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* **This regulation supersedes AR 40–2, 2 June 1975, including all changes.**

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CHAPTER 1

GENERAL

1–1. Purpose and scope. *a*. This regulation establishes policies and sets forth general administrative provisions for the operation of Army medical treatment facilities (MTF). Except as otherwise provided in certain chapters and paragraphs, this regulation applies to all Active Army MTF.

b. This regulation is applicable to the US Army Reserve and the Army National Guard.

Note: The words "he" and "his" as used in this regulation are intended to include both masculine and feminine genders and any exceptions to this will be so noted.

1–2. Responsibility of commander. The term "commander," where used in this regulation, means the commander of a MTF. The commander's responsibility includes, but is not limited to, the following:

a. Command of the MTF.

b. Ensuring that directives from higher authority are observed; that the spirit and intent of such directives are reflected in local regulations; and that local appropriate regulations and instructions are suitably posted throughout the facility and available to those persons to whom they apply.

c. Devoting all available resources in an efficient and economical manner toward the primary mission of providing the highest quality of patient care.

d. Insuring that medical records are properly safeguarded and that information from these records is released only in accordance with the instructions contained in regulations governing the release of information from medical records.

e. Maintaining an emergency operations plan, coordinated with other commands and agencies, as appropriate, based on the facility's total emergency expansion capability.

f. When also commanding an installation, discharging the functions and responsibilities of an installation commander set forth in AR 210-10, AR 5-3, and other regulations.

1–3. Recommendations for civilian care. When an individual requests the commander or any member or employee of his command to recommend a civilian hospital, physician, or dentist to provide medical or dental care, under no circumstances will the individual be referred to a specific hospital, physician, or dentist.

1–4. State and local laws and ordinances. As a general rule, State and local laws or ordinances dealing with hospital operation or administration are not binding on an Army MTF. The basis for this freedom is the constitutional immunity of a valid function of the Federal Government from State or local regulation. As a matter of policy, or in compliance with Army regulations, there may be times when a particular State or local law or ordinance should be complied with even though there is no legal requirement to do so.

1–5. Membership in local, State, or regional hospital associations. The determination whether a particular Army hospital should seek membership in a local, State, or regional hospital association rests with the commander. The cost of membership in such an association must be financed within local fund availability. Justification for the expenditure of funds requires that membership will prove beneficial directly to the hospital as an entity rather than solely to the individual members of the hospital staff. See AR 1-210.

1–6. Forms. *a*. Department of the Army forms listed below are prescribed for use, as required, in Army MTF:

Form No.	*Title*
DA Form 3586	Report of Professional Officer of the Day
DA Form 3821	Report of Administrative Officer of the Day
DA Form 3910	Death Tag
DA Form 3911	Physical Medicine Treatment Record
DA Form 3981	Transfer of Patient
DA Form 3982	Medical and Dental Appointment
DA Form 4029	Patient's Clearance Record
DA Form 4167	Ward Pass List
DA Form 4375	Patient's Interward Transfer

b. DA Form 4303 (Titling Card, Photofluorographic Film) provides an effective method for photographing the name of a patient, place of examination, and identification number. It is suitable for use in MTF's which use 70 mm photofluorographic equipment.

★*c*. DD Form 2005 (Privacy Act Statement—Health Care Records), figure 1-1, implements certain requirements of 5 USC 552a (The Privacy Act) for all forms used in the Outpatient Treatment,

Health, Dental and Inpatient (Clinical) Record or which facilitate or document treatment. Prior to collecting any personal information (except in an obvious emergency situation), insure that the patient is informed of information contained in DD Form 2005 and that acknowledgement is indicated by signature of the patient on the form. In cases where the individual refuses or is unable to sign DD Form 2005, a notation to that effect will be entered on the form. It will be dated and signed by the individual attempting to obtain the signature.

★*d.* DA Form 3910 (Death Tag). Prepare in triplicate (see TM 8-230 for detailed instructions). When the decedent is known to have had a communicable disease at the time of death, then that fact and the name of the disease will be annotated on the reverse side of DA Form(s) 3910.

1–7. Questionnaires. Questionnaires and other forms received by Army MTF's from professional or nonprofessional associations or individuals (other than requests covered in para 2-7, AR 40-66), in general, should be completed and requested information provided in accordance with the letter of instructions and associated forms contained in the questionnaire or survey received from the requester.

a. Information provided should be only that which does not require extensive compilation or research over and above normal operations. It should be restricted to that which is reasonably available and compatible with the Army Medical Department Health Information System. In cases where Army records do not contain the information or statistics requested, the forms should be so annotated. No attempt should be made to either generate statistics or maintain additional records in order to comply with requests for information contained in questionnaires or surveys.

b. Replies must be submitted to questionnaires received which are part of a US Government contract study. Depending on the subject of the study, these replies should be routed through the appropriate MACOM staff monitor.

c. Such information requirements will be approved under the provisions of chapter 9, AR 335-15 for requests from other Federal agencies. Contracts internal to the Department of the Army which levy such requests will be approved under chapters 3 through 5 of AR 335-15.

d. Questionable cases will be forwarded to the appropriate MACOM for review and/or release.

1–8. Laundry and drycleaning. *a. General Services.* The following laundry and drycleaning services at Government expenses are authorized for MTF:

(1) Linen, clothing, and bedding belonging to the AMEDD.

(2) Government-owned uniforms, coats, trousers, and dresses.

(3) Organizational linen and bedding of units assigned or attached to a MTF.

(4) Diapers and other linen of infant patients.

(5) Initial laundering or drycleaning of clothing worn by enlisted patients at the time of admission.

(6) Laundering of clothing and other personal items of individual patients when such clothing or items are in the MTF and are a menace to health or sanitation.

b. Prohibited services. Uniforms of civilian employees provided for by monetary allowances under authority of the Federal Employees Uniform Allowance Act or given employees in lieu of allowance will not be laundered or drycleaned at Government expense. See AR 670–10.

c. Personal services. Within available limits of facilities, laundry and drycleaning service will be afforded the military staff of the MTF, personnel of medical units assigned or attached to the MTF, and medical military personnel at nearby stations. Charges for these services will be at prescribed rates.

1–9. Duty personnel. *a. Enlisted personnel.* Enlisted personnel assigned to hospitals will be organized into a unit or units commanded by Medical Service Corps officers detailed for that purpose by the commander.

b. Uniform and clothing requirements. The commander will prescribe the uniform to be worn by military personnel on duty. Protective clothing for personnel performing certain duties in MTF is authorized as shown below. Clothing so authorized will be issued and maintained at Government expense. For female personnel, see also AR 670–30 and AR 700–84.

(1) *Smock and trousers, medical/dental technicians.* These smocks and trousers are prescribed for wear by male officers of the Army Nurse Corps and Army Medical Specialist Corps, male warrant officers, male enlisted personnel, and male civilian employees who are assigned to nursing, dental, physical therapy, occupational therapy, radiology, laboratory, and pharmacy duties. Basis of issues is in CTA 8–100.

(2) *Other protective clothing.* CTA 50–900 authorizes issue of protective clothing to male and female personnel for wear while performing certain duties in a MTF.

(3) *Retaining protective clothing.* Officers of the Army Nurse Corps and Army Medical Specialist Corps, warrant officers, and enlisted personnel assigned to duties in (1) above are authorized to retain and take, on change of station, the smock, medical/dental technicians, and the trousers, medical/dental technicians, white, durable press, issued to them.

(4) Items of field clothing authorized in CTA 50–900 as indicated (3) above, discretionary/organizational will be issued to members of the Army Nurse Corps and be in their possession at all times in order to meet the necessary readiness posture demanded of the AMEDD. These items will be retained by the individuals upon change of station.

c. Identification badges for hospital duty personnel. Hospital duty personnel (both military and civilian) will wear a badge while on duty which clearly shows the wearer's last name. Hospital commanders will prescribe other characteristics of the badge (e.g., rank/grade and duty position) and the manner of wearing. Local procurement of these badges as nonstandard items of medical supply, using appropriated funds available for financing the operation of the MTF, is authorized. These badges do not replace and are not to be confused with the name plate prescribed for military personnel in AR 670–5 and AR 670–30.

1–10. Facilities. *a. Use of MTF.* An MTF will be used only for medical activities. Medical activities, for this purpose, are defined as activities which relate directly or indirectly to patient care and treatment. The commander will determine which activities properly relate to patient care and treatment. At an MTF which is also an installation, normal installation activities are considered to relate to patient care and treatment.

b. Medical facility buildings.

(1) Except as indicated in (2) and (3)

below, buildings initially constructed or subsequently converted to house MTF or AMEDD personnel will not be altered, modified, or diverted from their intended use without prior authority of the US Army Health Services Command. Authority for conversion to other purposes without provision for reclaim in the event of a requirement will be granted by the US Army Health Services Command where no present or foreseeable future medical requirement exists. Approval of the US Army Health Services Command also will be obtained prior to making any major changes in the functional arrangement or layout of any part or portion of an MTF. MTF include hospitals, health clinics, troop clinics, laboratories, dental and other clinics, and quarters specifically constructed for AMEDD personnel, including civilian personnel.

(2) The installation or removal of such items as electrical fixtures, utility connections for new or obsolete equipment, or temporary partitioning may be accomplished within the approval authority of the installation commander without reference to higher authority.

(3) Outside the United States, major oversea commanders are delegated authority to take final action with respect to requests arising in base rights areas where such facilities are not under the authority of the US Army Health Services Command.

(4) Direct communication between installation commanders of installations having a staff surgeon and the US Army Health Services Command for the purpose of requesting diversion of MTF and MTF buildings to other purposes is authorized. For those installations not having a staff surgeon, direct communication between major CONUS commands and the US Army Health Services Command is authorized.

(5) All requests for diversion of MTF and MTF buildings to other purposes will contain the recommendation of the applicable staff surgeon.

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

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

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

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

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

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

3. ROUTINE USES

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

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

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

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

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

Patient, John K. Smith, unconscious SP/4 Paul C. Anderson 5 Apr 77

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE

DD FORM 1 FEB 76 2005 PREVIOUS EDITION IS OBSOLETE.

Figure 1–1. Privacy Act Statement—Health Care Records.

CHAPTER 2

PATIENTS

Section I. MANAGEMENT OF PATIENTS

2–1. Control. *a. Military patients.* The commander has administrative authority to restrict the freedom of action, to include restraint, of a patient under his command, provided such restriction or restraint is not imposed as punishment for an offense or for disciplinary reasons, but is a reasonable and necessary incident of the proper medical care and treatment of such patient. See section IV, chapter 5, AR 600–20, concerning medical care. With reference to military discipline and good order, all military patients are subject to the provision of the Uniform Code of Military Justice.

b. Nonmilitary patients.

(1) Nonmilitary patients admitted to an Army MTF have an obligation to conform to the rules and regulations governing the operation of the facility. If a patient, who has no statutory right to medical care in an Army MTF, fails or refuses to comply with the facility rules and regulations, he becomes liable to discharge from the facility at the discretion of the commander. Whenever a beneficiary of the Veterans Administration is discharged from a facility under these conditions, the commander will forward to the Administrator of Veterans Affairs, through the Regional Office, a notification (exempt, para 7-2*k*, AR 335–15) giving the patient's name and address, the reasons for his early discharge, and any other information which may be pertinent. Similar action will be taken with respect to any patient so discharged who is a beneficiary of any other Government agency. The report will be sent to the head of the agency employing the patient.

★(2) Usually nonmilitary patients who are well enough to be absent from the facility are medically fit to the extent that discharge is warranted. However, in unusual circumstances, when the commander determines it to be in the best interest of the patient, nonmilitary patients may be authorized to be absent from the facility for periods up to 72 hours without being discharged therefrom. Patients in this status will not be charged nor will they be credited with occupying a bed during such absences.

2–2. Identification. *a. Newborn.* Immediately subsequent to the birth of an infant in an Army MTF and prior to removal of the infant and mother from the delivery room, identification will be accomplished. Two identical items of identification will be placed on either the wrists or the ankles of the infant. A third identical item will be placed on the wrist of the mother (using the wrist not used for the mother's personal identification as provided in *b* below). Entries on the identification items will include the mother's full name, mother's register number, sex of the infant, and date of birth. The infant discharge procedures will include positive comparison by the individual removing the infant from the facility between the items of identification on the infant and the mother. Immediately prior to release of the infant from the facility, one of the items of identification will be removed from the infant and included with his clinical record. The other items of identification will remain with the infant until the infant is removed from the facility.

b. Pediatric and adult patients. A tamperproof, nontransferable identification band will be placed on either wrist of the patient. This band will be checked before each and every procedure performed on the patient unless positive identification is known. Identification data on the insert card of the band will include the patient's full name and register number. Used bands may be discarded upon departure of the patient from the facility. Standard identification bands will be used. In individual cases, where medical contraindications exist, the use of this identification procedure may be omitted or altered.

2–3. Patient welfare program. (This paragraph applies only to fixed hospitals.)

a. Purpose. The patient welfare program is an integral part of the Army medical care program. It encompasses functions or activities which contribute to the comfort, recreation, contentment, or entertainment of patients, thus improving morale and speeding the recovery of patients. It is recognized that duty personnel and visitors may derive inciden-

tal benefits from this program, but that fact in no way will be considered as justifying any part of the program.

b. Means. The patient welfare program will be implemented by use of—

(1) The facilities of the Special Services activities at the installation where a MTF is located. The cost of supplies, equipment, and services (including maintenance and repair) will be met through the use of appropriated funds, except that when appropriated funds are not available, the supplies, equipment, or services, equipment, or services may be provided from the sources stated in (2) and (3).

(2) The services of the American Red Cross, United Services Organization, and other welfare organizations.

(3) Nonappropriated funds, including the medical holding unit fund, and central post fund, and the central hospital fund.

c. Supplies, equipment, and service. Supplies, equipment, and services used in the patient welfare program must contribute directly to the comfort, entertainment, recreation, or contentment of hospitalized patients and must benefit the patients as a group rather than individuals. The commander's decision whether a particular item of supply or equipment or service is a proper part of the patient welfare program is final.

2–4. Comfort items for patients. *a. General.* The hospital commander may designate an officer under his command to receive and receipt for a sum of money not to exceed $15 per month from the accrued pay of a member who has been declared mentally incompetent in accordance with the provisions of AR 40–3 and who is a patient in his hospital. This money may be used only for the purchase of comfort items for the use and benefit of such members. However, withdrawals as described above may be authorized only when all of the following conditions exist:

(1) A legal guardian or other legal representative has not been duly appointed to act for the member.

(2) The member must have no other funds available for use in his behalf. (Moneys held in trust in the Patients' Trust Fund to his credit will not be considered as funds available.)

(3) The patient requires the items to be purchased, as determined by competent authority.

(4) The patient's condition is such that he is able to use the items purchased.

(5) Such items are beneficial to the patient's comfort and well-being.

b. Receipt. The funds will be receipted for by the officer designated on behalf of the mentally incompetent. The voucher will reflect this paragraph and regulation as the authority for receipt.

2–5. Reading service. Reading service for the use of patients may be accepted by the commander.

a. Normally, a reading service will be limited to the following:

(1) Racks which hold current magazines inclosed within binders.

(2) The name of the donor and his business address may be stamped on the binders or inserted inside the covers.

(3) Pamphlets containing information about the donor, his business, or products may be placed in small containers attached to the magazine racks.

b. Acceptance of a reading service will not involve any expense to the Government.

c. Any advertising matter displayed in connection with a reading service will not bring or reflect discredit upon the military service.

2–6. Special reporting to Veterans Administration. *a.* Under Veterans Administration regulations, the date of a veteran's admission to a uniformed services hospital is accepted as the effective date of claim for disability benefits provided that a previous claim for compensation or pension was filed by the patient. It is not necessary that such compensation or pension was ever received.

b. To ensure adequate reporting of appropriate cases to the Veterans Administration for further adjudication by that agency, inquiry will be made as a part of patient admission processing to establish whether non-active-duty individuals who have had military service have previously submitted a claim to the Veterans Administration for compensation or pension. In affirmative cases, VA Form 21–8358 (Notice to Veterans Administration of Admission to Uniformed Services Hospital) will be completed by the Admitting Officer or that patient administrator. This form will be forwarded in accordance with instructions contained thereon within 24 hours following admission of the patient. The filing of this form with VA Regional Office or Center is exempt from reports control under paragraph 7–2*k*, AR 335–15. Subsequent reports required by the Veterans Administration will be furnished upon request subject to the provisions of AR 335–15. Supplies of VA Form 21–8358 will be requested through normal publications channels.

Section II. EFFECTS, CLOTHING, AND EQUIPMENT

2–7. Government property. A military patient sent to a MTF normally will leave his individual weapons and organizational equipment with his organization. If a patient brings Government property to a MTF, it will be properly safeguarded. When a patient is admitted, his effects will be inventoried immediately and Government-owned weapons and other organization equipment will be returned to his organization, if possible, and a receipt obtained and filed with patient's records. Otherwise the commanding officer of the medical holding unit will place this property in the custody of the supply officer.

2–8. Personal effects. When a patient is admitted, two copies of DA Form 4160 (Patient's Personal Effects and Clothing Record) will be prepared and sent with the patient to the patient's clothing room. Here the patient's personal property, other than money or valuables, will be inventoried, listed on both copies of DA Form 4160, and placed in a clothing bag. The bag will be tagged for identification using DD Form 599 (Patient's Effect Storage Tag) and securely stored. The contents of luggage or other containers in the patient's possession need not be inventoried, but each piece of luggage or other container will be tagged (DD Form 599) and listed on DA Form 4160. Each piece of luggage or container not equipped with a secure locking device will normally be sealed in the patient's presence. All items inventoried will be listed in the first numbered column of DA Form 4160. All entries on the form will be made in ink except for the identifying information entered by the admission office. Unused lines in the column will be ruled out. The column will be dated and then initialed by the patient and the clothing room clerk. One copy will be given to the patient as his receipt and the other copy retained in the patient's clothing room.

2–9. Patients unable to sign. An officer from the Medical Hold Unit, admission office or administrative officer of the day, after normal duty hours, at the time of admission of a patient unable to sign the inventory will witness and sign for the patient.

2–10. Withdrawals. When a patient withdraws any of his clothing or property, the inventory

column of DA Form 4160 (both copies) will be redlined and any remaining balance entered in the next numbered column. The patient and the clothing room clerk will verify the new balance by initiating the column. When a patient withdraws all of his clothing and property, he will surrender his copy of DA Form 4160. If a patient leaves on a temporary basis and withdraws all of his clothing and effects, the form may be held until his return and then, beginning with the next open numbered column, be reused.

2–11. Discharge. Patients discharged from the facility will reclaim all personal clothing and property. The patient and the clothing room clerk will sign the appropriate spaces on the reverse of the clothing room copy of DA Form 4160 which is then dated and filed (the patient's copy will be destroyed).

a. If a patient dies, absents himself without leave, deserts, or otherwise unaccountably departs from the hospital, his effects will be disposed of in accordance with instructions contained in AR 630–10, AR 638–1 and AR 700–84.

b. When a patient is transferred to another medical treatment facility, his effects may accompany him or they may be forwarded. See AR 700–84 and AR 735–5.

c. Excess clothing and baggage of patients transferred to a community nursing home under VA contract (para 6–22*b*, AR 40–3) will be shipped by the military unit commander to the patient's home or other location designated by the patient prior to transfer of the patient. Clothing and baggage of mentally incompetent patients, which cannot be disposed of to a guardian or NOK, will be transferred to the VA and managed in accordance with VA instructions.

2–12. Loss of DA Form 4160. If a patient loses his copy of DA Form 4160, a duplicate will be prepared by the clothing room clerk, prominently marked "COPY," and given to the patient. A notation will be made on the clothing room copy of the date the duplicate was issued.

2–13. Exceptions. The commander may exempt any patient or group of patients from the procedures outlined in paragraphs 2–8 through 2–12.

2–14. Hospital clothing. Hospital clothing will be made available to patients for wear during their stay in the MTF. Commanders may authorize individual patients or groups of patients to wear personally owned pajamas and robes. When hospital clothing is issued to patients, entries will be made in the spaces provided on DA Form 4160 for this purpose.

2–15. Medical property and supplies. *a. Separation.* Upon separation from the service, a patient may be permitted to retain any medical property or appliances then in his use which are necessary for his physical comfort and safety. The responsible property officer will drop this property from his property book and submit DA Form 3122 (Request for Issue and Turn-in) explaining the circumstances, as a voucher, to which will be appended the patient's receipt for the property. Issue of supplies and equipment from the stock fund property account is not authorized. Provision of necessary supplies and equipment will be accomplished through purchases charged to funds which finance the operation of the facility. See paragraph 4–15, AR 40–61.

b. Shipping instructions. These items may be shipped on a Government bill of lading. Payment for shipment will be made from funds for shipment of medical property.

CHAPTER 3

RECORD ADMINISTRATION

Section I. TERMINAL DIGIT FILING OF MEDICAL RECORDS

3–1. Purpose. *a.* This section provides for the filing of inpatient (clinical) records, outpatient treatment records, and X-ray film files at Army MTF and those health and dental records which have been authorized to be filed under the terminal digit filing system.

b. All health records and all dental records prescribed for military personnel by AR 40–403 are not required to be filed under the Terminal Digit Filing System (TDFS), but are authorized to be so filed as locally desired.

3–2. Effective date. Conversion to the TDFS occurred on 1 January 1969. Those completed clinical records, existing outpatient treatment records, and X-ray film files retrieved from previous years' files will be converted to the TDFS. No attempt will be made to convert an existing file until such time as it is retrieved and utilized. Records falling in this category will be converted to the TDFS based on the sponsor's social security number (SSN).

3–3. Definitions. For the purpose of this section, the following definitions apply:

a. Inpatient (clinical) record. An inpatient record is that record which is prepared for every patient, military or civilian, admitted to an MTF, including newborns, and other cases carded for record only. See AR 40–400.

b. Outpatient treatment record. An outpatient treatment record is that file which is maintained for each outpatient who has been treated at an MTF and for whom maintenance of a health record is not required by AR 40–403. See AR 40–400.

c. Health record. The health record is that record which is initiated and maintained for all Army personnel on active duty, or active duty for training; for cadets of the United States Military Academy; members of the Navy and Air Force; and military prisoners while confined in US military facilities. See AR 40–403.

d. Outpatient dental record. An outpatient dental record is that record which is maintained for each outpatient receiving dental treatment for whom maintenance of a health record is not required by AR 40–403 and AR 40–400.

3–4. Related regulations. AR 340–18–1 and AR 340–18–9 provide for the orderly maintenance, retirement, and disposal of records.

3–5. General. *a.* The principal characteristic of the Terminal Digit System is filing of records by the terminal or last four digits of the sponsor's social security number, rather than alphabetical filing by name. The terminal digits include a primary group or last two digits and a secondary group or second last two digits; i.e., in SSN 790–22–3753, the 3753 are the terminal digits, the 53 is the primary group, and 37 is the secondary group.

b. Regardless of the size of the file, the primary group numbers are arranged from 00 to 99. Within each primary group, the material is arranged by the secondary group members, also from 00 to 99; the remaining figures are filed in numerical order. If the file identified by 390–22–3734 is desired, the file clerk goes to the primary group "34." Within this group, the secondary group "37" is located, and within this group the folder with digits 39022 is selected. In other words, instead of reading a social security number 327–37–4321 in the

usual manner, read the first two digits at the extreme right, "21," as the primary group. Then read the next two digits to the left of 21, which are 43. Last, read the remaining digits in the group 32737. Commas, spaces, hyphens, and alphabetical characters are disregarded if they appear.

c. To obtain positive control over misfiling, file folders and negative preservers are color tinted and blocked. The color of the file folder and negative preserver indicate a given group of numbers; e.g., orange represents primary groups 00 through 09, light green represents 10 through 19, and by blocking out one of the preprinted digits along the border (0 through 9), it will represent the last digit of a series of numbers, such as "3" in SSN 790–22–3753.

d. File guides may be distributed throughout the files, approximately 8 to 10 inches apart, to facilitate filing and refiling.

e. The DA Form 3443 and 3444 series are the only preservers/folders authorized for use in the filing of inpatient (clinical) records, outpatient treatment records, health records, outpatient dental records, and X-ray films under the TDFS. They will be requisitioned from US Army AG Publication Centers. Existing stocks of terminal digit file folders, DD Form 722 (Health Record) and DD Form 722–1 (Health Record—Dental) file folders in MTF may be exhausted prior to using these series. Existing terminal digit files may be retired or forwarded in present folders. Existing terminal digit file folders will be replaced by the DA Form 3444 series, as proper maintenance dictates.

3–5.1. Characteristics of DA Form 3444 series.
a. DA Form 3444, Alphabetical and Terminal Digit File for Treatment Record, has characteristics similar to and replaces DA Form 3444, 1 Nov 1968, but provides additional capability of both alphabetical or terminal digit filing in one folder without modification for use according to filing system required or desired. This capability then allows transfer of records from a facility with a limited number of records, where alphabetical filing is an advantage, to a facility with numerous records, where terminal digit filing is best, without changing the medical record jacket. The upper left patient identification is used primarily to facilitate alphabetical filing, whereas upper right numerical identificaton blocks accommodate terminal digit filing. Only the appropriate ID need be completed. If a patient is transferred to a facility where the alternate system of filing is more convenient, the additional ID section may be completed without modification or change of record jacket. The block labeled patient identification on the right front cover may be utilized in conjunction with the Patients Recording Card for outpatient care or the 9-line admission plate for inpatient care, as appropriate. The block in the lower right edge of front cover should be taped for cases where it has been medically determined that the patient should not have direct access to his/her medical records as they contain information which may be harmful to his/her mental or physical health (see para 2–6*e*, AR 340–21). Folder provides for identifying individuals with special medical conditions (those necessitating a medical warning tag) under AR 40–15, enrolled in the Personnel Reliability Program under AR 50–5, recording blood type as outlined in AR 40–403, AR 40–400, and this regulation, identifying those on flight status, central registries, and radiation exposure lists. A second clasp has been added to increase flexibility to the outpatient treatment and inpatient (clinical) records as well as meeting the requirements of the Health/Dental Record. Preprinted DD Form 2005, Privacy Act Statement, and DA Form 4410–R, Disclosure Accounting Record, have been added to reduce preparation time and meet requirements of the Privacy Act.

b. The old series of DA Form 3444, 1 Nov 68, will continue to be used for inpatient (clinical) records and outpatient treatment records until current supplies are exhausted. DD Form 722 and 722–1 will continue to be used until record covers must be replaced through normal deterioration, when records are prepared for personnel entering active duty, or when locally desired by the record custodian for terminal digit filing.

3–6. Preparation of DA Form 3444 series. *a. General instructions.* The DA Form 3444 (Terminal Digit File For Treatment Record) series of folders consists of ten color tinted folders, DA Form 3444 and DA Form 3444–1 through 3444–9 for filing clinical records, outpatient treatment records, and, when locally desired, health records (para 2–4*b*, AR 40–403).

(1) Utilizing the last two digits (primary group) of the SSN, select a folder according to the color scheme below.

Primary group	*Color of folder*	*DA Form*
00–09	Orange	3444
10–19	Light green	3444–1
20–29	Yellow	3444–2
30–39	Grey	3444–3
40–49	Tan	3444–4
50–59	Light blue	3444–5
60–69	White	3444–6
70–79	Brown	3444–7
80–89	Pink	3444–8
90–99	Red	3444–9

(2) Affix identification label, prepared in accordance with *b*(1) or *c*(1) below, in the space provided on folder.

(3) Code the last digit of the primary group from the SSN by placing ½" of black tape over or by blocking out in black ink the corresponding number on the edge of the folder, wrapping the tape around the edge of the folder. A 1" length of tape should suffice to provide a visible mark on both front and rear of folder. Record the last digit of the primary group in the block on the upper edge of the folder to the extreme right.

(4) Record the two digits of the secondary group from the SSN in the two blank blocks provided at the upper right, along the top edge, to the left of the primary grouping, with a fiber tipped pen or other marking device. Record the remaining numbers of the SSN and family member prefix in the spaces provided when locally preferred or when mechanical imprinting of this data is not utilized.

(5) Record the retirement date by placing ½" colored tape to the block marked "R," extending it around the edge of the folder as in (3) above. When the retirement date changes (e.g., patient treated in 1974 is again treated in 1975), this block will be re-color coded in keeping with the instructions herein. The color code to be utilized is determined according to the following scheme.

Records to be retired	*Color*
1977	Yellow
1978	Silver or white
1979	Black
1980	Orange
1981	Red
1982	Blue
1983	Green
1984	Yellow
1985	Silver or white
1986	Black
1987	Orange

(6) Record status of patient by placing ½" colored tape to the block marked "S," in the manner described in (3) above, according to the following:

Records described in AR 340–18–9 by file number	*General group*	*Color*
918–01, 919–01	Military	Red
918–03, 919–03	Foreign nationals	Silver or white
918–02, 919–02	All others	Black

(7) Check appropriate block on right side of the front cover to indicate manner in which the folder is to be utilized; inpatient (clinical) outpatient, health, or dental.

(8) When appropriate, check the block on the left side of the front cover to indicate the proper note to physician and affix label when required.

(9) Prior to collecting any personal information ensure that patients are informed of DD Form 2005 (see para 1–6*c*).

b. Special instructions for inpatient (clinical) records.

(1) Prepare an identification label utilizing the patient's recording card (para 3–8), when mechanical imprinting is available, or containing the data and in the format as prescribed for lines 1 and 3 of the patient's recording card, when such equipment is not available, and place it in the space provided on top right of front cover. In lieu of the above, when locally desired, the admitting plate (table 2–2, AR 40–400) may be stamped on the front upper right of the folder.

(2) The retirement year for clinical records will be that prescribed in AR 340–18–9.

c. Special instructions for outpatient treatment records.

(1) Prepare an identification label, utilizing the patient's recording card or lines 1 and 3 of its format in a manner similar to paragraph *b*(1) above and place it in the space provided on top right of front cover. In lieu of the above, when locally desired and it can be clearly read, the above data may be printed directly on the folder.

(2) The retirement date for outpatient treatment records, excluding foreign national files, will be 3 years after the annual cutoff date. For example, a record is initiated in 1974 and color coded for tentative retirement in January 1978 by placing a strip of silver or white tape over the block printed "R." When the record is first brought into use during 1975, the silver or white tape will be covered by a black tape to indicate a new tentative retirement date of January 1979.

(3) A nominal card index will be maintained on plain 3 by 5 cards for outpatient records filed by the TDFS as a cross-reference between patient's name and SSN. Only information pertaining to treatment records in file will be maintained.

3–7. Preparation of DA Form 3443 series. The DA Form 3443 (Terminal Digit X-ray Film Negative Preserver) series consists of ten color tinted preservers, DA Form 3443, and DA Forms 3443–1 through 3443–9 for filing X-rays, and is prepared in a manner similar to the DA 3444 series of folders (para 3–6). Space provided will be used for a chronological record of exposures.

Section II. IDENTIFICATION AND RECORDING PLATES AND CARDS

3–8. Patient's recording card. *a.* The use of patient's recording card is the method of choice for the entry of identifying data on forms filed in the outpatient treatment record (AR 40–400) or health record (AR 40–403). It is used with the ward or clinic identification plate described below.

b. The patient's recording card should be prepared when the patient is first examined or treated in a troop or health clinic.

c. The patient's DD Form 1173 (Uniformed Services Identification and Privilege Card) or DD Form 2A (Active Duty Military ID Card) should be used to obtain the necessary data to be embossed on the patient's recording card.

d. The patient's recording card may also be used as an appointment card by attaching an adhesive-backed paper appointment notice to the back. The clinic receptionist or central appointment clerk fills in the date, time, and clinic on the next blank line of the appointment notice. The information is then readily available to the patient and to clinical personnel during the patient's next visit. The appointment notice also has space provided for the identity, location, and telephone number of the MTF.

e. Suggested identifying data to be embossed on the patient's recording card are illustrated in figure 3–1.

f. Information of a local nature may be embossed on the patient's recording card as changes in local requirements exist. The optical card reader font will be used for the family member prefix and SSN to provide an aid in filing of medical documents. Since there are frequent referrals to a MTF other than the MTF at which a patient's record is normally maintained or situations occur wherein patients receive treatment at a number of MTF, information identifying the MTF which is custodian of the patient's record should be imprinted on the patient's recording card.

g. As indicated above, the patient's recording card is designed for ease of printing identification data on records only. It will not be utilized to determine eligibilty for care as such determinations are made in accordance with AR 40–3.

3–9. Ward or clinic identification plate. This plate provides for the identification of the MTF and the nursing unit, clinic, or other functional elements as permanent data in the imprinting device and incorporates an easily changeable rotary dater. It is used in conjunction with the inpatient identification plate (para 3–10) or the patient's recording card (para 3–8). Suggested format for the ward or clinic identification plate is as follows:

LINES 1 AND 2—Name and location of MTF.
LINE 3—Identification of the nursing unit, clinic, or other functional elements using the imprinter.

3–10. Inpatient identification plate. *a.* This plate provides patient identification information for use on all forms in the clinical record; it is used with the ward or clinic identification plate described above.

b. Suggested format for the inpatient identification plate is as follows:

LINES 1 and 2—All spaces—Blank.
LINE 3—Spaces 8 through 23—Patient's name (last, first, middle initial).
Space 24—Blank.
Spaces 25 through 29—Rank, grade (CPT, SFC), or status (Depn, TDRL, Ret, or OFEC).
LINE 4—Space 8 through 15—Register number.
Space 16—Blank.
Space 17 through 29—Family member prefix and sponsor's SSN (para 3–12).
LINE 5—Space 8—Sex (M–Male, F–Female).
Space 9—Blank.
Spaces 10 through 12—Age.
Spaces 13 through 29—Blank.

c. When not in use, the patient's identification plate will be filed in an alphabetical locator file.

d. Upon transfer of a patient to another nursing unit, the plate will be attached to the patient's chart and transferred with the patient.

e. When the patient is ready for final disposition, local procedures will govern the use of the plate. Plates which have served their purpose will be discarded.

3–11. Patient bed card. This card will be prepared on plain 3-inch by 5-inch card stock using a bulletin-type typewriter, if available. If a bulletin-type typewriter is not available, the card may be handlettered. The format of the information to appear on the card is—

a. Patient's first name, middle initial(s), last name.

b. Rank, grade, or status.

c. Service affiliation (Army, Navy, Air Force).

d. Date of admission.

3–12. Use of the social security number (SSN) with a family member prefix. This paragraph prescribes the use of the SSN with a family member prefix, for the identification of medical record forms, files of clinical and outpatient medical records, and for the TDFS prescribed in section I of this chapter.

a. The first two digits, the family member prefix, identify the patient as follows: Oldest child of sponsor (adopted, legitimate, or illegitimate child or stepchild) in the order that they become eligible—01; next oldest child—02; third oldest child—03, etc.; Sponsor (prime beneficiary)—20; Spouse—30; Mother—40; Father—45; Mother-in-law—50; Father-in-law—55; other relatives (to include preadoptive children) who are determined to be eligible for medical care—60, 61, 62, etc.; all civilian emergencies, and all others not mentioned above—00. When a member remarries and adopts children who are older than his own, the family member prefixes which were previously assigned to his children should not be changed. A family member prefix should be assigned to adopted children in the order that they become eligible for medical care regardless of the age of the child. The other nine digits, the SSN of the sponsor, are broken into 3 groups, the first group consisting of 5 digits, and the second and third groups consisting of

2 digits each. Example: PFC Ernie Jones, SSN 390–22–3734, would be identified as 20 39022 37 34; his wife's number would be 30 39022 37 34, his third oldest child's number would be 03 39022 37 34.

b. The sponsor's SSN will be used for identification of dependents. When both parents are on active duty, the children's number will reflect the SSN of the father.

c. The military service number of foreign military members will be used in lieu of an SSN for these individuals and their dependents.

d. In the case of retirees, their dependents, and dependents of deceased members not having a SSN, the service number will be used.

e. For cases described in *c* and *d* above, the number will be preceded by sufficient zero digits to create an eleven-digit number plus spaces. Example: 20 00000 11 23; 30 00000 11 23, etc.

f. Artificial numbers, consisting of eleven digits and three spaces, will be constructed and assigned to patients for whom numbers are not prescribed in *a*, *b*, *c*, or *d* above, or who do not have an SSN. The two-digit family member prefix will always be 00; the next five digits, corresponding to the first group of an SSN, will identify the specific patient, beginning with 00001 for the first patient in this category and numbering subsequent patients in this category consecutively; the other two groups of two digits will always be 00 00; e.g., 00 00001 00 00; 00002 00 00.

Section III. REPETITIVE RECORD WRITING

3–13. Application. Mechanical record writing techniques may be employed for repetitive tasks such as: Studying length of patient stay; periodical patient reporting; entry of identifying information on numerous forms and other identifying administrative information; preparing roster, manifests and listings; and identifying locator files and documents. Many of these compilations may be prepared by running the entire file through the listing machine printing only the desired information from the plates. This is accomplished by the selector mechanism and the tabbed plate units. The implementation of these procedures is fully justified throughout many areas of an Army MTF. These suggested procedural applications are in addition to those listed elsewhere in this and other regulations.

3–14. Authorization. *a.* Mechanical record writing systems are authorized for use in fixed Army hospitals where the volume of admissions and dispositions warrant procurement of the necessary equipment. The local situation and workload will determine the advisability of implementing these systems in clinics. Equipment, replacement items, and supplies may be procured in accordance with established procedures and within authorization prescribed by applicable tables of allowance. These systems may be used in all fixed MTF. Hospitals using automatic data processing procedures may adopt appropriate portions of this regulation for procedures not accomplished by automatic data processing.

b. Mechanical record writing techniques may be employed in any area of MTF for repetitive writing tasks. Examples are:

(1) *Medical supply.* Preparation of inventory count cards, stock status reports, and requisitions. Plates may be used for imprinting certification of funds, stock fund, and obligation authority on various documents.

(2) *Administrative offices.* Preparation of rosters, envelope addressing, routing slips, publications distribution, and any other forms of standard distribution.

(3) *Pharmacy.* Preprinting labels, bulk orders, and requisitions.

c. TOE medical units performing their stated TOE mission normally will not have mechanical record writing equipment.

3–15. Equipment. The following or similar equipment, FSC Group 74, is necessary for implementing these systems. Model types should be determined locally.

a. Addressograph embossing equipment, Class 6400 series or equal, for embossing identifying information of the admitting plates, patient's plates, and/or patient's recording cards (metal or plastic).

b. Addressograph listing equipment, Class 1900 series or equal, with attachments (for hospitals only).

c. Addressograph data recorders for recording information from the patient's identification plates, or from the patient's recording card to the various forms and reports.

3–16. Supplies. *a. Selector tab.* A metal tab which is affixed to the top of the admitting plate unit to permit use of mechanical selection features of the equipment.

b. Laminated plastic patient's recording cards ($3\frac{1}{2}'' \times 1\frac{23}{32}'' \times .108''$).

c. Ink roller platens.

d. Adhesive-backed appointment cards. These cards have spaces for listing appointments and for the name, address, and phone number of the MTF.

e. Admitting plate. A rectangular plate for use in the admitting offices.

f. Frame. A metal carrier for the admitting plate.

g. Index card. A small card placed on the frame to identify the admitting plate. This is made by imprinting the first two lines of the plate.

h. Identification plate. A small rectangular plate embossed with patient identifying information for use by nursing unit personnel. (The term "nursing unit" is synonymous with the word "ward.")

3–17. Use of tabs. For selective automatic listing perforated lock tabs may be used. Local requirements will determine the extent to which this feature is employed.

Section IV. PROTECTION OF MEDICAL RECORDS

3–18. Special status of medical records. *a.* Medical records generated within the Army are the property of the United States. As such, these records are subject to the control in the manner prescribed by law and regulations for Government documents. (For a list of statutory provisions and executive orders, and a discussion of these, consult AR 340–17.) Medical records further enjoy a special status since they contain much information which is of concern only to an individual and his physician. In order to avoid confusion of terminology, this status will be referred to as "private" rather than "confidential" (which is a defense information classification) or "privileged" (which is a legal term and is subject to interpretation according to jurisdiction) or "safeguarded" (which is a special document classification within the Army). It should be kept in mind that in addition to the general classification of "private," medical records may also require protection according to the other systems of classification referred to whenever the content of a particular record meets the requirements of the particular system.

b. Because of their private status, medical records are subject to limited access. Within the Department of the Army, information from such records or the records themselves will be made available only for treatment and other official purposes.

c. As a matter of course, a private medical record must be seen by various clerical and administrative personnel (such as secretaries, stenographers, medical record administrators, patient administrators). This circumstance does not create any inherent right of access, but is merely an extension of the physician's and the MTF's responsibility for proper prepa-

ration and processing of records. All of these individuals have a professional and moral obligation to keep inviolate information obtained from private medical records in the course of their work. Unauthorized disclosure of private medical information is proper ground for the administrative or disciplinary action against the informant.

d. For specific provisions and procedures governing release of information to individuals and agencies see AR 340–17, AR 340–21, AR 40–42, AR 40–400, AR 40–403, and AR 600–85. Requests for information in medical records from insurance companies, compensation commissions, and similar private and governmental agencies will be favorably considered when the patient (or his parent, next-of-kin, or legal representative, when appropriate) has authorized furnishing the requested information and when responding to the request will not involve unreasonable effort or expense. Standard Form 544 (Clinical Record—Statement of Patient's Treatment) is designed for use in responding to such requests. The copy of SF 544 with courtesy, if required, will be forwarded to requestor. A copy of the completed SF 544 and written authorization for release of the information, will be filed as prescribed in section II, chapter 6, AR 40–400. See AR 37–30 and AR 340–17 concerning fees and charges for copying certification, and search of records for various classes of patients.

3–19. Medical records and paramedical documents. Medical records, which must be considered as private, consist of those individual medical and clinical documents containing information regarding findings, diagnosis, or therapy recorded by or for the physician or dentist, outpatient treatment records, clinical records, health records, and X-rays. Paramedical documents prepared in accordance with other requirements, such as immunization registers, dosimetry records, and so forth, are not included in this definition even though they may sometimes be found in the same file or folder containing other medical records.

3–20. Responsibility for protection of medical records. Each individual who handles private medical records is responsible for protecting these records from exposure to any but authorized individuals. The MTF commander is responsible for promulgating local rules and regulations which will guarantee adequate protection of private medical records. All requests to a MTF for the release of information from medical records will be coordinated through the patient administrator, or, in the absence of such an individual, another designated representative of the MTF commander.

3–21. Defense information in medical records. Whenever a medical record contains information which is classified under the provisions of AR 380–5, the record will be examined by the custodian of medical records of the facility. If this examination shows that the classified portions of the record may be deleted or withdrawn from the record without injury to the clinical information in the record, the classified portions will be deleted or withdrawn. Where information is withdrawn it will be filed separately and a notation entered in the clinical record that classified information, not affecting the clinical contents, has been withdrawn and filed elsewhere. When the classified portions of the record cannot be deleted or withdrawn without injury to the clinical information, the entire record will be classified and handled in accordance with the provisions of AR 380–5.

3–22. Safeguarded information in medical records. A medical record will not be marked in accordance with AR 340–16 or be considered a safeguarded record (as defined in AR 340–16) solely be virtue of being a medical record. The provisions of paragraph 3–21 dealing with classified information are equally applicable to medical records which contain information falling within the description in AR 340–16.

3–23. Research in medical records. *a. General.* Army medical records in MTF, Army records centers, and in facilities of the General Services Administration may be made available to qualified individuals for the purposes of research

Data for Patient's Recording Card

Line	Space	Description of Information
1	1 through 14	Family member prefix and SSN (para 3–12).
	15 through 22	Blank.
2		Blank.
3	1 through 22	Patient's name (last, first, middle initial).
4	1 through 4	Year of birth.
	5	Blank.
	6	Sex (M—male, F—female).
	7 through 12	Blank.
	13 through 16	Status of patient or of sponsor if patient is a dependent (AD, RET, TDRL, CIV, VA, or PW).
	17	Blank.
	18 through 22	Department of patient or of sponsor if patient is a dependent.
	1 through 3	Three-character abbreviation of grade or rank of patient, or of sponsor if patient is a dependent; otherwise, leave blank.
	4	Blank.
	5 through 22	Sponsor's name if patient is a dependent; otherwise, leave blank.

Figure 3–1

and study. Space and facilities will be furnished by the custodian to authorized researchers. Medical records will not be removed from the premises of the custodian for the purpose of such research. Commanders of medical facilities will not borrow retired records for use by researchers.

b. Responsibilities.

(1) The Surgeon General is responsible for approving requests for access to medical records for research and study, except as indicated in (2) below.

(2) Commanders of Army MTF are responsible for approving requests from personnel under their command jurisdictions for access to medical records in their facilities.

c. Applications. Except as indicated in *b*(2) above, all requests originating outside of Department of Army for access to Army medical records for research and study will be addressed through channels to HQDA (DASG-HCP) WASH DC 20310. The applications will contain the following information:

(1) Name and address of the researcher, and any assistants.

(2) Professional qualifications of the researcher, and any assistants.

(3) Description of the project or field of study in which the researcher is engaged.

(4) Reason for requesting the use of Army records.

(5) Particular records to which access is requested and their location.

(6) Inclusive dates during which access is desired.

d. Conditions. Prior to being granted access to medical records, each individual named in the application will be required to sign an agreement stating that—

(1) Information obtained from Army medical records will be treated in accordance with the ethical principles of the medical profession.

(2) The identity of individuals referred to in the medical records will not be divulged without permission of the individuals concerned, and photographs of an individual, or any exterior portion of the body of an individual will not be released without the consent of the individual concerned.

(3) The researcher understands that permission to examine the records does not imply approval of the project or field study by The Surgeon General.

(4) All identifying entries pertaining to an individual will be deleted from abstracts or reproduced copies of medical records.

(5) Any published material or lectures on

the particular project or study will contain a statement as follows:

The use of Army medical records in the preparation of this material is acknowledged, but it is not to be construed as implying official approval of the Department of the Army of the conclusions presented.

3–24. Request procedures. *a. Request form.* DD Form 877 (Request for Medical/Dental Records or Information) may be used for requesting medical records. This form is designed for use with a window envelope. It will be typewritten.

b. Initial action by requesting activity. Complete items 1 through 10 (except 8b) and item 19. Check the appropriate boxes in item 8a to indicate whether military records, Veterans Administration records, or both are required. Forward the original and duplicate copy of the form to the custodian of the desired records and retain the triplicate copy.

c. Action by addressee.

(1) If the requested records are available, the following action will be taken:

(*a*) Complete item 8b and items 11 through 14 of DD Form 877. Check the appropriate box(es) in item 8b to indicate whether military records, Veterans Administration records, or both are forwarded.

(*b*) Forward the ribbon copy of DD Form 877 with the requested records to the addressee indicated in item 19.

(*c*) File the duplicate copy of DD Form 877 in lieu of the records transmitted to indicate that the records have been removed from file. If records are withdrawn from more than one file, a charge card containing a statement substantially as follows will be placed in each additional file from which records are withdrawn:

(Type of records) pertaining to (name(s)), social security number, (service number(s)) were forwarded to (address) on (date) in compliance with DD Form 877 received from (address). These records covered treatment during (inclusive dates).

Upon return of the records the duplicate copy of DD Form 877 will be destroyed, and the charge cards ,if used, will be withdrawn from file.

(2) If the requested records are not on hand but their location is known (e.g., in The Adjutant General's Office or in another MTF) forward both copies of DD Form 877 to the present custodian of the records, using items 11 through 14. The latter office will use items 16 through 18 to make final reply to the request. However, if the records have been transferred or loaned, the request will be forwarded to the organization in possession of the records by completing items 15 through 18.

(3) If the requested records are not on hand and the location is unknown, return both copies of DD Form 877 to the requesting activity, using items 11 through 14.

d. Final action by requesting activity.

(1) If the medical records were borrowed from an Army MTF or a records center, and the borrowing MTF did not create additional records on the patient, the borrowed records will be returned promptly after they have served their purpose by completing items 15 through 18 of DD Form 877. If these items have been used, the records will be returned by correspondence with the ribbon copy of DD Form 877 as an inclosure.

(2) If the MTF created additional records on the patient, the borrowed records will become part of the file created by the borrowing hospital and the original DD Form 877 will be destroyed.

CHAPTER 4

PATIENTS IN SPECIAL CIRCUMSTANCES

4–1. General. This chapter prescribes procedures for preparing and maintaining certain records pertaining to very seriously ill and seriously ill patients, deceased persons, and patients in certain special categories; and contains authority for the commander to order autopsies under specific circumstances. Notifications required under this chapter are exempt from reports control under provisions of paragraph 7–2*k*, AR 335–15.

4–2. Very seriously ill (VSI), seriously ill (SI), and special category (SPECAT) patients. *a. Definitions.*

(1) A patient is *very seriously ill* when his illness is of such severity that *life is imminently endangered.*

(2) A patient is *seriously ill* when his illness is of such severity that there is cause for immediate concern, but there is no imminent danger to life.

Note. These definitions are to be applied literally. Pursuant to international agreements, the US Army is required to furnish information to certain foreign nations concerning VSI and SI patients. The action taken by these nations hinges in many respects on which category the patient is placed in.

(3) A patient is *special category* when his next of kin (NOK) needs to be provided information regarding the following conditions even though he is not classified as VSI or SI:

(*a*) Sustained a severe injury, such as loss of sight or limb.

(*b*) Sustained a permanent and unsightly disfigurement of a portion of the body normally exposed to view.

(*c*) Suffering from an incurable and fatal disease and have limited life expectancy.

(*d*) Has an established psychotic condition.

(*e*) May require extensive medical treatment and hospitalization.

(*f*) Being released from the service under the provisions of AR 635–40 for a psychiatric condition, when such notification is deemed appropriate by the medical officer and the written permission of the patient is obtained. Notification should include advice on additional treatment required and, if known, civilian facilities in the patient's community from which assistance may be requested.

(*g*) Paralyzed.

b. Records (for use in noncombat areas).

(1) *DA Form 2984 (Very Seriously Ill/Seriously Ill/Special Category Patient Report).* When a medical officer determines that a patient is VSI, SI, SPECAT, changes from one category to the other, or subsequently recovers, dies, or is transferred to another MTF, he will prepare DA Form 2984 and forward it by rapid means to the patient administrator, administrative officer of the day, or other designated officer for action.

(2) *Roster of VSI, SI, SPECAT Patients (locally produced).* The patient administrator or other designated officer will prepare daily a roster of VSI, SI, and SPECAT patients. As a minimum, the roster will reflect the name, grade or status, SSN or other identification number, ward, date first placed on the roster, and present condition. The format of the roster, the method of preparation, and the distribution will be locally determined.

c. Notification procedures.

(1) The following notification procedures apply to CONUS MTF in notifying NOK and other authorized persons within CONUS. For exceptions, see (2) below. In oversea areas AR 600–10 applies.

(*a*) Upon classification of a patient as VSI or SI, the commander will immediately notify the NOK or other person to be notified. A followup notification (progress report) will be sent not less frequently than every 5 days and immediately upon a significant deterioration in the patient's condition. A final notification will be sent when the patient is removed from VSI/SI.

(*b*) When the person to be notified resides in CONUS, the notification will be sent direct. Telegraphic or telephonic means of communication will be used as appropriate. Verification of such notification will be made immediately by letter in those cases in which the NOK are not in close proximity to the hospital and in regular and frequent contact with the hospital or the patient. When the person to be notified is not located in CONUS, or notification of NOK is not within the capability of the responsible hospital commander, the casualty information will be relayed immediately to the Casualty Area commander (para 5–13, AR 600–10).

(*c*) When Army personnel are hospitalized in nonmilitary hospitals, the commander of the MTF administratively responsible for the patient will be responsible for notification procedures.

(*d*) When the NOK or person ordinarily notified is present in the MTF, the commander may modify the procedures involved, so long as the NOK is kept fully informed of the condition and progress of the patient.

(*e*) A special category patient will be counseled concerning the advisability of informing a member of his family of his condition. He will be advised and encouraged to write personally when he is physically and mentally able to do so. If the patient is unable to write, assistance should be provided from volunteer workers or hospital staff members. If the patient is a military member under legal age and he refuses to inform his family, the commander, if he considers it in the best interest of the patient, may communicate information regarding the patient's condition to the NOK. In all other instances the fact of refusal and the name of the officer receiving the refusal will be noted in the patient's clinical record. When a patient is unable to act in his own best interests and cannot communicate intelligently with his family, the commander will notify the NOK. The notification will not include the specific diagnosis, but will be couched in lay language.

(2) *Exceptions.* The notification procedures detailed above do not apply to the following categories of patients:

(*a*) Prisoners of war (see Art 122, CG 1949, DA Pam 27–1).

(*b*) Enemy nationals see Art 138, CG 1949, DA Pam 27–1).

d. Notifications pursuant to international agreements.

(1) In addition to all other notification requirements, when personnel of Armed Forces of Allied Nations or foreign national students are patients in CONUS US Army MTF, the commander in whose area the casualty occurs will provide the casualty area commander information on which to prepare a casualty report in accordance with paragraph 3–11, AR 600–10.

(2) The NATO agreement implemented by this paragraph is STANAG 2132.

(3) The ABC agreement implemented by this paragraph is SOLOG 74.

4–3. Deceased persons. *a. Notification.* Whenever a person dies at an Army MTF, the commander will submit the reports required by AR 600–10 and ensure that a certificate of death is prepared for each deceased person. The commander has similar responsibilities for deceased persons who are dead upon arrival at the MTF. The medical officer in attendance at the time of death, or, in the case of the dead on arrival, who pronounces a person dead, will initiate DA Form 3894 (Hospital Report of Death) and forward it, ordinarily by hand carry, to the patient administrator or administrative officer of the day. The officer receiving the report will ensure that notifications required by AR 600–10 are made, and that other appropriate actions indicated in DA Form 3894 are taken. (In the case of fetal death, DA Form 3894 should be initiated only when a still birth or fetal death certification and burial permit are required by local law. The physician in

attendance at the time of delivery or abortion is responsible for seeing that the DA Form 3894 is initiated and forwarded to the patient administrator. Reports will be accomplished in the care of fetal or still deaths only in oversea cases when the father is in an area other than that oversea command at the time of the death of his child. Other actions indicated in DA Form 3894 are not usually appropriate in such cases.

b. Care and disposition of remains. AR 638-40 deals with preparation and disposition of remains. Local laws of the area in which an MTF is located may impose requirements with regard to handling remains. The commander should be familiar with these local requirements and their application to his facility.

★*c. Laws governing the registration of fetal deaths (completion of fetal death certificates) vary among the States.* Army MTF's may dispose of fetal remains in accordance with local law. Where the gestational age of the fetus, or weight, in the absence of gestational age information, meets the statutory requirement for registration, written authorization for disposal of the fetus will be obtained from the primary next-of-kin(NOK).

★*d.* Disposition of liveborn infants, regardless of duration of life or gestational age, will be through a licensed funeral director (see AR 638-40).

4–4. Autopsy authority or consent. *a.* Commanders may authorize autopsies performed on the remains of members of the military departments who die in the military service, while serving on active duty or active duty for training, as follows:

(1) When it is considered necessary for the protection of the welfare of the military community to determine the true cause of death or to secure information for the completion of military records.

(2) When death occurs while the member is serving as an aircrew member in a military aircraft an autopsy is mandatory.

★*b.* In cases not covered in *a* above, when an individual dies in an Army MTF or on a military installation, consent from the spouse or NOK must be obtained, except as provided in (1) and (2) below, before an autopsy is performed.

(1) If applicable State laws compel the performance of an autopsy, the commander may order an autopsy performed without the consent of the spouse or NOK. In such cases, the record will clearly document the reason for not obtaining consent from spouse or NOK.

(2) In oversea areas where local laws and regulations require an autopsy, and the United States has not been exempted from such laws or regulations by treaty or agreement, the commander will order an autopsy performed without the consent of the spouse or NOK. The record will clearly document the reason for not obtaining consent from spouse or NOK.

c. In cases not covered in *a* above, when an individual dies outside a military installation and is dead on arrival at an Army MTF, the authority for autopsy is governed by the applicable local laws unless the local authority specifically relinquishes such right, in which case the provisions of this paragraph apply.

d. Authorization or consent for the performance of an autopsy, will be recorded on SF 523 (Clinical Record—Authorization for Autopsy). Where pertient, the applicable law, regulation, treaty, or international agreement will be cited as authority. The local judge advocate should be consulted when necessary (e.g., when definition is needed for "NOK" for the jurisdiction in which the facility is located).

e. All autopsies will be performed promptly to preclude delayed release of remains to mortuary officials. The prosector will employ techniques which offer minimum interference with the embalming process, particularly with respect to the circulatory system and which minimize disfigurement. Provided the prosector concurs, embalming may be performed prior to autopsy. All autopsies will be recorded on SF 503 (Clinical Record—Autopsy Protocol).

CHAPTER 5

HOSPITAL ACCREDITATION

5–1. General. This chapter deals with the Department of the Army program for the accreditation of United States Army hospitals by the Joint Commission on Accreditation of Hospitals.

5–2. The Joint Commission on Accreditation of Hospitals. The accreditation of hospitals is a function of the Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Il 60611. This commission is composed of representatives of the American College of Physicians, American College of Surgeons, American Medical Association, and the American Hospital Association.

5–3. Objective. It is an objective of the Department of the Army that—

a. All eligible US Army hospitals located within the 50 United States be accredited by the Joint Commission on Accreditation of Hospitals, and

b. All AMEDD hospitals comply with the Joint Commission of Accreditation of Hospitals standards on medical care evaluation (chap. 10, AR 40–400).

5–4. Standards of accreditation. *a.* The basic criteria for accreditation are contained in the Joint Commission's "Accreditation Manual for Hospitals," 1976.

b. Certain standards which have special interpretation for Army hospitals are contained in the Joint Commission's publication, "Guidelines for Field Representatives to use in Surveying Hospitals of the Federal System," and chapter 10, AR 40–400.

5–5. Procedure. *a.* HQDA (DASG–HCP) WASH DC 20310, will be advised through command channels at such time as a hospital commander considers that his facility meets the requirements for accreditation.

b. The Surgeon General will request the Joint Commission on Accreditation of Hospitals to conduct initial surveys at eligible United States Army hospitals.

c. Applications for succeeding surveys and copies of Interim Self-Surveys will be forwarded through proper channels to HQDA (DASG–HCP), WASH DC 20310.

d. Upon completion of the survey by the Joint Commission, the hospital will so notify HQDA (DASG–HCP), WASH DC 20310, through proper channels.

e. The payment of fees incident to surveys for accreditation will be accomplished by The Surgeon General, Department of the Army.

f. The executive committee of each inpatient Army MTF will keep its entire medical and administrative staff informed concerning the Joint Commission on Accreditation of Hospitals program, the current accreditation status of the MTF, and the factors influencing that status.

CHAPTER 6

PATIENTS' TRUST FUND

6–1. Purpose. This chapter prescribes the methods by which patients' personal funds and valuables will be accounted for and controlled in Army hospitals.

6–2. Scope. This chapter is applicable to patients' trust funds (hereinafter referred to as PTF) at all Army hospitals. Commanders of major commands outside the United States will adopt such portions as are applicable and may establish appropriate procedures and controls in connection therewith.

6–3. Definitions. For the purpose of this chapter, the following definitions will apply.

a. Funds. The term "funds" will include all domestic currency and coins, cashier's checks, traveler's checks, checks drawn on the Treasurer of the United States and checks drawn on another PTF, when accepted for deposit.

b. Valuables. The term "valuables" will include all negotiable and nonnegotiable instruments not included in *a* above, valuable papers, and other personal effects such as jewelry, watches, rings, billfolds, foreign coins or currency, and items such as expensive cameras and binoculars. If the patient is the sole indorser on a negotiable instrument made payable to him, he may, if he so desires, strike his indorsement thus rendering the instrument nonnegotiable while it is in the custody of the fund custodian.

c. Responsible individual. An individual who is responsible for transactions relative to deposits in the PTF when the patient is unable to deposit directly with the custodian or assistant custodian.

d. Intermediate individual. An individual within each professional department or service who is charged with specific responsibility for all transactions between patients who have established an account with the PTF and the custodian of the PTF that require the services of an intermediate recipient.

6–4. Administration. *a. General.* No council is necessary for the administration of a PTF. The PTF is specifically excepted from the provisions of AR 230–1. Other instructions issued pertaining to or referring generally to "nonappropriated funds" will not apply to a PTF unless specifically made applicable thereto.

b. Responsibilities of the commander. The commander will be responsible for the overall operation of the PTF and for the proper safeguarding of patients' funds and valuables. Specifically, he will—

(1) Designate in writing an officer, warrant officer, or civilian employee as custodian of the PTF.

(2) Designate in writing such additional individuals as are required for the efficient operation of the PTF (alternate or assistant custodian, cashiers, bookkeeper, responsible and intermediate individuals, and hospital AOD/SDO) will be limited to the minimum necessary for efficient operation of the PTF.

(3) Determine the amount of cash to be kept on hand in the change fund and notify the custodian in writing of the amount authorized. Ordinarily only sufficient money should be kept on hand to satisfy the day-to-day demands for the withdrawal of funds. The amount authorized will be reviewed annually.

6–5. Custodian. *a. Responsibilities.* The custodian of the PTF will be responsible for the receipt, safekeeping, disbursements, and accounting for patients' funds and valuables

deposited with the fund. If the custodian is absent in excess of 30 days, the hospital commander must appoint a replacement to assume the duties of the custodian, accepting and receipting for patients' funds and valuables.

b. Transfer of funds and valuables to successor custodians. When a custodian is relieved and a successor custodian designated, transfer or accountability of the PTF will be accomplished as follows:

(1) The retiring custodian will close and balance the DA Form 4128 (Patients' Trust Fund Journal) as of the date of transfer to include a cash (on hand) count and a trial balance of the funds on deposit per DA Form 3696 (Patient's Deposit Record). In addition, a bank reconciliation will be prepared to show both the bank and journal balances together with the outstanding checks not yet paid as of the date of transfer.

(2) The joint statement below will be prepared in quadruplicate and all copies signed by the retiring custodian:

Statement of Outgoing Custodian

I have, this ____ day of _____ 19__, transferred to _____, the new custodian, $_____ cash on hand and $_____ on deposit to the credit of the Patients' Trust Fund in _____
(Name of bank)
_____ and all items listed on patients' deposit records.

_____
(Signature)

_____
(Grade and *SSN*)

Statement of New Custodian

I have, this ____ day of _____ 19__, received from _____, the sum of $_____ representing the balance due patients, together with the valuables listed on the individual patients' deposit records, and I hereby relieve him from all responsibility for the Patients' Trust Fund.

_____
(Signature)

_____
(Grade and *SSN*)

(3) Records, keys, cash valuables, etc., will be turned over to the succeeding custodian, who will sign all copies of the above statement after satisfying himself that no discrepancy exists.

(4) When actual transfer of the PTF has been accomplished, the original of the above statement, accompanied by a signature card bearing the signature of the new custodian, will be forwarded to the hospital commander. The hospital commander will give written notice of the change to the local bank and will inclose the signature card of the new custodian. The three remaining copies of the above custodian's statement will be distributed to the outgoing custodian, the new custodian, and the files of the PTF.

(5) Where a safe has been provided for the use of the custodian, the combination will be changed as prescribed in AR 37–103.

6–6. Operating principles. *a.* Items other than funds and valuables will not be accepted for deposit in the PTF.

b. Personal firearms, other weapons, including pocket knives with blades beyond the length permitted by law or regulations, and any other item or object which could be considered a menace to safety or health, other than Government property, will be receipted for and turned over to the Commander, Medical Holding Unit, or other responsible officer for safekeeping and disposition.

c. The PTF will not be used for the safeguarding of funds and valuables belonging to individuals not in inpatient status.

d. No investments or loans may be made with the funds on deposit.

e. No donations or contributions may be made or received by the fund.

f. Under no circumstances will money deposited in the PTF be used for purposes of cashing checks. Cashier's checks, traveler's checks, checks drawn on the Treasurer of the United States, and checks drawn on another PTF will not be cashed but will be accepted for deposit as cash if properly indorsed. Checks other than the above will not be accepted for deposit as cash.

g. Disbursements will be made by check whenever practicable. Disbursements will be made only to a patient who is a depositer (whether or not he is physically able to sign the necessary forms) except as follows:

(1) A disbursement may be made to the intermediate individual upon written authorization of the patient depositor.

(2) A check may be drawn payable to the individual assuming custody of a mentally incompetent patient upon discharge.

(3) A check may be drawn payable to the custodian of a PTF for a cash on hand reimbursement.

(4) A check may be drawn payable to the Treasurer of the United States for the transfer of unclaimed money or overages.

h. In those hospitals where various elements are located separately or at considerable distance from one another, the commander may authorize the operation of a separate subfund. This subfund will operate as prescribed herein, with the custodian of the PTF retaining responsibility for its operation. The custodian will authorize the transfer of the applicable deposit records and establish a change fund. Daily or weekly, as appropriate, a summary of all receipts and disbursements and cash on hand will be prepared in duplicate, and the original submitted together with a deposit or request for reimbursement of change fund, as applicable, to the (main) PTF. Totals from the summary of subfund transactions will be posted separately to the Patients' Trust Fund Journal. All check disbursements will be made by the (main) PTF.

i. The custody and accountability for the funds and property of hospitalized prisoners in accordance with AR 210–174 is the responsibility of the commander of the installation confinement facility to which the prisoner is assigned. The custodian of the PTF will not be designated the custodian of the prisoners' personal deposit fund; however, the PTF may be used for the safekeeping of those belongings of hospitalized prisoners which prisoners are permitted to retain. Other items must be placed in the prisoners' personal deposit fund.

6–7. Safeguarding of funds and valuables. The custodian will maintain positive control over all funds and valuables to ensure that accountability may be estabilshed to a designated individual at all times. When funds or valuables are transferred from one individual to another, receipts will be utilized.

a. Bank deposits. Cash receipts above the amount authorized to be retained on hand in the change fund will be deposited promptly in a local bank, except as provided in (2) below. All funds deposited in the bank will be placed in a checking account. Use of banking facilities and protection of deposits in banks will be in a manner similar to procedures outlined in AR 230–1.

(1) Funds will be deposited to the credit of the "Patients' Trust Fund Account." In addition to the official designation of the fund, the name of the account will include the words "an instrumentality of the United States." Moneys which do not pertain to the PTF will not be deposited in this account except as provided in paragraph 6–6 for funds of hospitalized prisoners.

(2) At the smaller hospitals where the total amount of money available for deposit is insufficient to preclude the payment of bank service charges, funds will not be deposited in a bank unless the custodian secures assurance from the bank that the service charge will be waived.

b. Valuables. Valuables will be placed in a safe or other container or room which provides the same degree of protection.

c. Loss of funds or valuables. When a shortage in the funds or a loss of property is discovered, the matter will be promptly investigated and disposed of, and appeals and requests for reconsideration processed, in a manner similar to procedures outlined in AR 230–1 for nonappropriated funds and in AR 15–6. When losses of funds are not recoverable and it has been determined that there was no fraud, dishonesty, or willful misconduct associated with the loss and no one is held pecuniarily liable, the fund should be constructively liquidated and a claim or claims initiated against the Gov-

ernment in accordance with provisions of AR 27–20. This may be accomplished as follows:

(1) List the names of the depositors in chronological order of their admittance;

(2) Place the amount deposited by each depositor opposite his name; and

(3) Reimburse each depositor in chronological order by the amount opposite his name until the fund is exhausted.

(4) The depositor or depositors who are not fully reimbursed will be assisted by the MTF commander in preparing a claim.

6–8. Forms. The following forms will be used to record deposit and withdrawal of funds and valuables:

a. DA Form 3696 (Patient's Deposit Record). This form will be prepared at the time a patient initially wishes to deposit his funds or valuables and will clearly show the patient's register number which will serve as the individual account number for the patient for PTF transactions.

b. DA Form 3983 (Patients' Trust Fund—Authorization for Deposit or Withdrawal of Funds and Valuables). This form will be prepared in duplicate for every deposit or withdrawal of funds and valuables (other than the initial deposit) requiring the services of an intermediate recipient, except where the Military Payroll Money List is used for deposits or a roster of patients is used for purchase of comfort items.

6–9. Procedure upon admission. When a patient is admitted to the hospital, the clerk who processes his records will explain to the patient that the hospital will receive his funds and valuables for safekeeping and that the hospital assumes no liability or responsibility for the loss of funds or valuables while they are in the patient's possession. After the examination, if the patient desires not to make a deposit, a DA Form 3696 will be prepared and the statement block indicating that no deposit is desired will be signed by the patient or witnessed, if the patient is unable to sign, and the form will be forwarded to the custodian. This procedure need not be utilized by those facilities that have established other means of recording the patients' desire of not utilizing the PTF.

6–10. Initial deposits. *a.* If the patient desires to make a deposit, the patient's deposit record will be prepared in duplicate by the admitting clerk. The patient will take both copies to the custodian who will enter a description of the funds and/or valuables and deposit them. The patient will sign the block that he desires to make a deposit and the custodian that he has received the funds and valuables on both copies. The original will be retained by the custodian and the duplicate will be given to the patient as his receipt.

b. When the deposit cannot be handled as a direct transaction between the patient and the custodian, the deposit record will be prepared in triplicate by the admitting clerk and all copies signed by the patient. The responsible individual will receipt for the deposit on the triplicate copy of the deposit record and give it to the patient or forward it to the intermediate individual of the professional service to which the patient is assigned, whichever is applicable. The original and duplicate copies of the deposit record, together with the funds and/or valuables, will be taken to the custodian by the responsible individual for deposit. The custodian will check the funds and/or valuables against the entries on the deposit record, and if the entries are correct, will sign both copies of the form. The original of the deposit record will be retained by the custodian and the duplicate will be returned to the responsible individual as his receipt.

c. When the patient's signature cannot be obtained because he is unconscious or otherwise physically unable to sign the deposit record (i.e., blind, or arm amputee), or when closed ward neuropsychiatric patients and patients under restraint for medical reasons refuse to cooperate in the preparation of the deposit record, the above procedures will be followed except that an officer or other responsible person (in the case of a nonmilitary patient, the sponsor or NOK, if present) will witness the transaction and sign all copies of the deposit

record. The patient will be searched when necessary in the presence of a witness. A brief statement as to why the patient's signature was not obtained (e.g., "unconscious," "NP Patient") will be entered on the custodian's copy of the deposit record. Additionally, in the case of nonmilitary patients, written acknowledgement will be obtained on the custodian's copy of the deposit record from the patient as soon as he is able to respond, or in the event he continues to be incapable of signing, the sponsor or NOK, where possible, in his behalf. The patient's copy of the deposit record for these patients will not be released to the patient, but will be retained by the intermediate individual.

6–11. Subsequent deposits. *a.* The patient will present his copy of the deposit record and the additional funds and/or valuables to the custodian. The custodian will itemize and enter the amount of funds and/or valuables, together with the date of deposit, on both his and the patient's copy of the deposit record. He will then sign both copies and return the patient's copy to the patient.

b. When the patient is physically unable to go to the custodian's office, DA Form 3983 will be prepared in duplicate and both signed by the patient. The duplicate will be signed by the intermediate individual and retained by the patient until the transaction is completed. The original, together with the additional funds and/or valuables and the patient's copy of the deposit record will be taken to the custodian by the intermediate individual. The custodian will make the appropriate entries on both copies of the deposit card, sign both copies, and return the patient's copy to the intermediate individual for delivery to the patient. The original DA Form 3983 will be returned to the custodian; the duplicate will be returned to the intermediate individual by the patient upon delivery of his copy of the deposit record.

c. When the patient's signature cannot be obtained, DA Form 3696 or DA Form 3983, as appropriate, will be signed by a witness as provided in paragraph 6–13*c*.

d. An additional copy of the DD Form 115 (Military Payroll Money List) of closed ward neuropsychiatric patients may be accepted by the custodian in lieu of individual authorization forms, provided each patient listed has signed the list.

6–12. Partial withdrawals. *a.* When a patient wishes to make a partial withdrawal of funds or valuables, he will present his copy of the deposit record to the custodian who will make the proper entries on both copies of the deposit record. The patient will sign both copies to receipt for the withdrawal. The custodian will require proper identification and will ascertain that the signature is authentic. The patient will retain his copy of the deposit record.

b. When the patient is physically unable to go to the custodian's office to make a withdrawal, DA Form 3983 will be prepared in duplicate and signed by the patient, the duplicate being retained by the patient. The original, together with the patient's copy of the deposit record, will be presented to the custodian by the intermediate individual for payment. The custodian will verify the patient's signature on DA Form 3983 and make the proper entries on both copies of the deposit record. The intermediate individual will sign both copies of the deposit record and return the money or valuables, together with the patient's copy of the deposit record, to the patient. The intermediate individual will receipt for the money or valuables on the original DA Form 3983 which will be retained by the custodian. The duplicate DA Form 3983 will be signed by the patient upon delivery of the money or valuables and given to the intermediate individual as his receipt. Where a periodic sales service of comfort items is provided on the wards, a copy of a roster of patients, showing name, grade, SSN, and amount of purchase may be used in lieu of individual DA Forms 3983 provided each patient acknowledges the purchase with his signature.

c. When a patient wishes to make a partial withdrawal but is physically unable to sign the necessary forms, one of the above procedures will be followed except that the signa-

ture of a witness will be secured in lieu of that of the patient.

d. The preferred method of handling partial withdrawals of funds or valuables by closed ward neuropsychiatric patients (except patients who have been declared mentally incompetent) and patients under restraint for medical reasons is a direct transaction between the patient and the custodian. Where this is not practicable, the procedure in *b* above will be followed. No partial withdrawals by patients in this category will be permitted unless the patient acknowledges receipt with his signature.

e. No partial withdrawls will be made from deposits of patients who have been declared mentally incompetent.

6–13. Withdrawals in full. *a.* Withdrawals in full will be handled in the same manner as partial withdrawals except that the patient will sign the custodian's copy of the deposit record in the block headed "Funds and Valuables received in full" at the top of the form. After a patient has withdrawn all funds and valuables and the account has been closed, the patient's copy of the deposit record will be destroyed immediately

b. When the patient is physically unable to go to the custodian's office, withdrawals in full will be handled in the same manner as partial withdrawals except that the intermediate individual will sign the custodian's copy of the deposit record in the block marked "Funds and valuables received in full" at the top of the form.

c. When the patient is physically unable to sign the required forms for withdrawal, the above procedures will be followed except that the signature of a witness will be secured in lieu of the patient's.

d. The preferred method of handling withdrawals in full by closed ward neuropsychiatric patients (except those who have been declared mentally incompetent) and patients under restraint for medical reasons is a direct transaction between the patient and the custodian. Where this is not practicable the procedure in *b* above will be followed. If the patient is unable to comprehend, the funds and/or valuables will be disposed of in the manner prescribed in paragraph 6–15. If the patient is able to comprehend, but refuses to sign DA Form 3696 or DA Form 3983, and is discharged or transferred (without a finding of mental incompetency), the funds and/or valuables will be disposed of in the manner prescribed in paragraph 6–16.

6–14. Disposition of deposits of patients transferred to community nursing homes. Funds and valuables of patients transferred to a community nursing home under VA contract (para 6–22*b*, AR 40–3) will be shipped by the military unit commander to the patient's home or other location designated by the patient prior to transfer of the patient. Funds and valuables of mentally incompetent patients, which cannot be disposed of in accordance with paragraph 6–15(1) and (2) below, will be transferred to the VA and managed in accordance with VA instructions.

6–15. Disposition of deposits of mentally incompetent patients. *a.* At the time of discharge or transfer, funds and valuables of mentally incompetent patients will be disposed of in accordance with one of the following procedures, listed in order of priority:

(1) Where a legal committee, guardian, or other representative has been appointed by a court of competent jurisdiction, the funds and valuables will be turned over to such committee, guardian, or representative.

(2) In the event (1) above cannot be followed, the funds and valuables will be turned over to the NOK, such NOK to be determined in accordance with the laws of the State in which the personal property is located. However, if the patient is not subject to military law, disposition of the property to the NOK should not be made without notification to local authorities responsible for the disposition of psychotic nonmilitary patients.

b. On the day of departure of the patient, the custodian will make and sign an inventory in duplicate of the patient's funds and valuables on deposit in the PTF. A check for any money on deposit will be drawn payable

to the appropriate individual assuming custody (*a*) above). The check will have plainly written on the face thereon "Credit Account of (Name of patient)."

c. The check and a copy of the inventory listing the patient's valuables, together with the valuables, will be turned over to the individual assuming custody and the individual's signature secured on one copy of the inventory for the records of the PTF. When funds and valuables of the patient cannot be turned over directly to the individual assuming custody, the funds and valuables will be forwarded to the individual assuming custody of the patient in a manner similar to paragraph 6–16*a* below.

6–16. Deposits remaining after disposition or transfer of patients (other than mentally incompetent). Under ordinary circumstances, the patient will withdraw funds and valuables on deposit with the PTF prior to departure from the hospital. Funds and valuables remaining on deposit after the departure of a patient will be disposed of as follows:

a. Forwarding address known. A check will be drawn to the order of the patient for the funds left on deposit. The check and a letter of transmittal will be forwarded to the patient at his new address within one working day after the patient's departure. A copy of the letter of transmittal will be filed with PTF records. Valuables will be sent by first class registered mail, return receipt requested. When valuables are forwarded, two additional copies of the inventory will be included with the letter of transmittal with request that one copy of the inventory be receipted and returned. Receipts and copy of transmittal letter will be filed with PTF records.

b. Forwarding address unknown. A letter requesting the current address of the former patient will be prepared, to include a detailed report of all pertinent circumstances, and forwarded to Cdr, US Army Enlisted Records and Evaluation Center, ATTN: PCRE–FM, Ft. Benjamin Harrison, IN 46249, for enlisted personnel and to HQDA (DAPC–PSR–SR) 200 Stovall St., Alexandria, VA 22332, for officer personnel. Upon receipt of the necessary information, the funds and valuables will be processed in accordance with *a* above. If this correspondence fails to locate the service member, an attempt to locate the NOK through correspondence with the Veterans Administration or the Red Cross should be made. When the location of the individual cannot be determined, the moneys left on deposit will be deposited with the local Finance and Accounting Officer in the manner prescribed in paragraph 6–17*d*(3) for outstanding checks. Valuables will be disposed of in conformance with DOD 4160.21–M.

c. Deposits of deceased patients. Funds and valuables left on deposit by patients who have died will be disposed of in conformance with AR 638–1.

d. Closure of hospital. Under normal circumstances, no funds or valuables should be on deposit when a hospital is to close. However, when a hospital within jurisdiction of the US Army Health Services Command about to close does have funds and valuables of former patients on deposit and there is not sufficient time to effect disposition, a notification will be submitted to The Commander, US Army Health Services Command, ATTN: HSOP–P, requesting designation of another hospital to which the funds and valuables may be transferred. The original deposit records will be forwarded with the funds and valuables to the designated hospital and the custodian receiving them immediately will take action indicated in *a* or *b* above, as appropriate. Major oversea commanders are authorized to take final action on requests rising within their commands.

6–17. Accounting for funds. The procedures outlined below are applicable primarily to those MTF having a relatively large volume of transactions. Where local conditions warrant, these procedures may be notified to suit the requirements of the individual facility, subject to the approval of the MTF commander, and provided the intent of this regulation is complied with.

a. Summary of deposits and withdrawals. At the close of business each day, a summary of deposits and withdrawals will be prepared using DA Form 4665–R (Patients' Trust Fund

—Daily Summary Record) (figs. 6–1 and 6–2), which will be locally reproduced, head to foot on 8-x-10½-inch paper. Each transaction involving a deposit or withdrawal from the PTF will be posted separately to the summary, showing the patient's name, the amount of deposit or withdrawal, and a breakdown by cash or check. Totals from the summary will be entered daily in the Patients' Trust Fund Journal.

b. DA Form 4128. The Patient's Trust Fund Journal (hereinafter referred to as the journal) will contain a daily summary of all money transactions with the PTF. Detailed entries of money transactions and deposits or withdrawals of valuables will not be entered in the journal.

(1) *General.* The following instructions are furnished for use in maintaining the journal:

(*a*) *Column* (*a*). Enter the date of entry.

(*b*) *Column* (*b*). Enter the total amount of receipts for the day.

(*c*) *Column* (*c*). Enter the total amount of cash disbursements for the day.

(*d*) *Column* (*d*). Enter the total amount of check disbursements for the day.

(*e*) *Column* (*e*). Enter the sum of columns (*c*) and (*d*).

(*f*) *Column* (*f*). To the previous day's balance, add the receipts shown in column (*b*), deduct therefrom the withdrawals shown in column (*e*), and enter the result. At the beginning of each month, the initial entry will be the fund balance brought forward from the last day of the preceding month.

(*g*) *Column* (*g*). To the previous day's balance, add the receipts shown in column (*b*), deduct therefrom the cash withdrawals shown in column (*c*), and enter the result except when it exceeds the authorized amount of the change fund. In this case, enter the authorized amount of the change fund, and record the difference between total cash on hand and the authorized amount of change fund "for deposit" in column (*h*). At the beginning of each month, the initial entry will be the change fund balance brought forward from the last day of preceding month.

(*h*) *Column* (*h*). Enter the amount for deposit as computed in column (*g*). Amount may be accumulated until a deposit is made.

(*i*) *Column* (*i*). Enter the number of the checks drawn to bring the change fund up to the authorized amount.

(*j*) *Column* (*j*). When the change fund falls below the authorized amount, a check will be drawn to bring the change fund up to the authorized amount. The amount of the check will be entered in this column.

(*k*) *Column* (*k*). Enter the sum of columns (*g*) and (*h*) or (*j*), as applicable.

(*l*) *Column* (*l*). Enter the bank balance per checkbook. At the beginning of each month, the initial entry will be the bank balance brought forward from the last day of the preceding month.

(*m*) *Column* (*m*). Enter the sum of columns (*k*) and (*l*). This figure should balance with the figures shown in column (*f*). At the beginning of each month, the initial entry will be the total fund balance brought forward from the last day of the preceding month.

(*n*) *Column* (*n*). Enter any pertinent remarks in this column.

(2) *Trial balance.* At the end of the month, the custodian will prepare a trial balance of all open accounts in the fund, listing the patient's full name or account (register) number and balance. Funds and valuables of patients found to have departed the MTF will be disposed of in accordance with paragraph 6–16.

(3) *Verification of balances.* Periodically the balances of the individual patients' deposit records will be added and reconciled to the balance shown in the journal. The total bank balance plus the cash on hand should be equal at all times to the amount shown on the patients' deposit records.

c. Checkbook. A checkbook will be maintained by the custodian. All checks will be numbered serially. This may be done by pen and ink or by a numbering machine. Such process will be accomplished immediately upon receipt of each new book of checks. Every disbursement by check will be entered in the checkbook, and the stub will be completely filled out. Deposits from cash receipts will be entered on the appropriate stub and running balance maintained. Canceled checks returned from the bank with the monthly statement will be filed

in numerical order. Voided checks will be marked "Void," countersigned by the custodian, and filed in numerical sequence with canceled checks. Each individual check will bear the following stamped statement on the reverse:

This check is not valid unless presented for payment within 12 months from the date of issue.

d. Bank account.

(1) *Deposit slips.* Duplicate slips will be obtained for each deposit for the files of the PTF.

(2) *Reconciliation of bank statement.* The bank statement will be reconciled at the end of the month and balanced to the journal, checkbook, and the cash on hand.

(3) *Outstanding checks.* At the end of each month, the custodian will determine from the bank reconciliation which checks have been outstanding for 12 months or longer from the date of issue and make all reasonable efforts to locate the payee in accordance with the procedure prescribed in paragraph 6–16. Failing in this, a letter, in duplicate, will be sent to the bank requesting stop payment on the check and requesting that the copy of the letter be returned with a notation thereon reflecting the date such stop payment was effected. Upon receipt of this notice from the bank, the amount of check will be entered in the checkbook as a receipt, with proper explanation on the stub, and included in the entry of total receipts for the day (colm (*b*)) in the journal with an appropriate notation in column (*n*), "Remarks." A check in the same amount will then be drawn payable to the "Treasurer of the United States" and forwarded to the local Finance and Accounting Officer for deposit in the trust fund account 20X6133 "Unclaimed Monies of Individuals Whose Whereabouts are Unknown (name of individual)," together with a letter containing all known details and a request that a receipt be furnished. This will be included in the entry of total check disbursements for the day (colm (*d*) in the journal and an appropriate notation entered in the remarks column. When the receipt is received from the Finance and Accounting Officer, it will be attached to the copy of the stop payment letter and made a part of the files of the PTF.

e. Overages. When an overage in the fund has been verified by audit, a check will be drawn payable to the "Treasurer of the United States" and forwarded to the local Finance and Accounting Office for deposit in the Receipt Account 211060 "Forfeitures of Unclaimed Money and Property."

6–18. Accounting for valuables. *a.* The deposit and withdrawal of valuables will be posted to the valuables portion of the patient's deposit record. Each item deposited will be accounted for individually except in the case of numerous items of similar nature and of little value such as several small denomination foreign coins, a group remark such as "foreign coins—5" may be used. The serial number of valuables having a number which is evident without dismantling should be entered on the deposit record. In the case of articles of considerable intrinsic value, including but not limited to cameras, watches, jewelry or rings, an appropriate description will be recorded on the deposit record to assist in identification of the item. The entry should describe the article without attempting to evaluate it; for example, "ring, gold color, with green stone," rather than "gold ring with emerald stone."

b. If space provided on the deposit record is not adequate for subsequent transactions, an additional copy of the deposit record will be prepared in the usual manner; clearly marked "No. 2 of 2" or the equivalent, as applicable, and stapled to the original.

c. Valuables will be kept in sealed containers, such as envelopes, cloth bags, or other appropriate containers, which will be clearly marked with the patient's name and account (register) number. All containers will be numbered (e.g., "No. 1 of 1," "No. 1 of 2," "No. 2 of 2"). Valuables may be wrapped, when necessary, and tagged with DD Form 599.

6–19. Audit. The PTF will be audited annually in accordance with AR 36–75 and at any other time that the MTF commander determines it appropriate.

(Locate figures 6–1 and 6–2, fold-in pages, at the end of the regular size pages and insert following this page.)

CHAPTER 7

PHARMACY MANAGEMENT

7–1. Application. This chapter applies to Army MTF inside and outside CONUS.

7–2. Responsibility. *a.* The commander is responsible for operation of the pharmacy. He will exercise careful supervision over all phases of its operations, including employment of recognized professional procedures and establishment and aggressive pursuit of such policies as are considered desirable to ensure conformity with the highest standards of the pharmaceutical profession. Supervision will be exercised either directly through a subordinate officer, who is a graduate of a recognized school or college of pharmacy and licensed to practice pharmacy in one of the States of the United States, Puerto Rico, or the District of Columbia, or, when no commissioned officer who is a pharmacist is on duty at the facility, an officer of the Medical Corps.

b. The commander is responsible for establishing policies to ensure rational prescribing, that quantities of drugs prescribed are not in excess of amounts required to provide sound medical treatment, and drug dispensing is based on a formulary system.

c. The officer in charge of the pharmacy will be charged with the duties of recognizing, identifying, selecting, preparing, safeguarding, testing, evaluating, and dispensing all substances of whatever kind and combination used in preventative or curative medicine (AR 40–4). He and his assistants will be responsible for keeping abreast of new developments in the field of pharmacy, and for passing on information about these developments to the professional personnel they serve. The officer in charge of the pharmacy will be responsible for—

(1) Assisting and advising authorized individuals in the writing of prescriptions, with particular reference to questions of pharmacology and toxicology, dosage forms and strengths, precautions, side effects and adverse drug reactions, availability of ingredients, size of standard packages, equivalent agents, therapeutic and physical incompatibilities, storage requirements, dosage calculations, factors leading to pharmaceutical elegance and palatability, use of agents and quantities for maximum effectiveness and economy, refill authorizations, and any matter involving the use or misuse of medications.

(2) Assisting and advising personnel of operating agencies within the facility whose duties involve stocking pharmaceutical items, by conducting inspections at least once monthly, or more often if required. Inspections will include, but will not necessarily be limited to, review of adequacy of identification, sufficiency of storage, safeguards, and evaluation of condition and potency of stocked items, based on normal expiration dates, assays, tests, observations, or such other criteria as are accepted as good practice by the pharmaceutical profession.

(3) Maintenance of adequate reference material for use by pharmacy personnel and the professional staff served by the pharmacy.

(4) Dissemination to the professional staff of information concerning advances in the field of pharmacy and related matters. Such information may be presented at symposia arranged for that purpose by the Chief of the Professional Services, or when this position is not authorized, by the professional service chief responsible for professional education matters.

(5) Arranging for dissemination of information to or "detailing" of members of the

professional staff by representatives of reputable procedures and distributors of therapeutic items; screening applicants to ensure that the representative is properly accredited; that appointments are made at the convenience of the potential prescribed; that duplications, annoyances, and detailing of unimportant items are avoided; and to ensure availability or potential availability of the items detailed.

(6) Development and dissemination of such local supplements to standard pharmacopoeias, selected therapeutic agents lists, or formularies, as may be required. A pharmacy newsletter may be used to disseminate timely information on drug items and preparations available for use along with other prescribing policies and items of interest to the professional staff.

(7) Proper storage, safeguarding, labeling, and dispensing of investigational drugs; establishment and maintenance of investigational drug files; and dissemination of essential information concerning investigational drugs to members of the nursing staff actively engaged in the administration of such drugs or in the care of patients receiving such drugs. See AR 40–7.

(8) Operating a pharmacy sterile products program commensurate with the need for this program within the hospital to include the preparation and delivery of pharmaceutical sterile products to the ward. Laminar air flow hood quality control requirements will include cleaning of the equipment used on each shift, microbiological monitoring as required by the infections control committee, and periodic checks for operational efficiency at least every 12 months by a qualified inspector. Appropriate records of such actions will be maintained.

(9) Implementing a unit dose drug distribution system, which permits identification of the drug up to the point of administration, as rapidly as materiel and personnel are available. The use of floor stock medications should be minimized.

7–3. Monetary collections for medicine. The pharmacy will not serve as a monetary collection agency for drugs or preparations dispensed.

7–4. Personnel. The officer in charge of the pharmacy will carefully screen all personnel assigned to the pharmacy to ensure that only qualified persons are permitted to compound or dispense drugs or pharmaceutical preparations of any kind. To the fullest extent possible, only persons who are graduates of accredited civilian pharmacy schools or specialists who have successfully completed a course of instruction at a pharmacy specialist course of the Armed Services, or a pharmacy course of equivalent scope, will be assigned professional or technical duties in the pharmacy. One or more graduate licensed pharmacists shall be assigned primary duty at all large military pharmacies at MTF where the range, variety, and complexity of drugs dispensed require a high degree of professional competence and supervision. At all such MTF pharmacies, drugs will be dispensed by graduate licensed pharmacists. At other installations where the use of a full time graduate licensed pharmacist would not be justified, pharmacies may be operated—

a. By part-time basis officers who are graduate licensed pharmacists but who are assigned other primary duties;

b. By part-time civilian graduate licensed pharmacists; or

c. By dispensing physicians.

Trained pharmacy specialists, either enlisted or civilian, may be used in pharmacies provided they function under the direct supervision of graduate licensed pharmacists or dispensing physicians.

d. During the hours that the pharmacy may be closed, amounts of drugs sufficient to provide treatment until pharmacy services are available may be directly dispensed from an after hours walk-in clinic or the emergency room by a physician or by authorized personnel under the direct supervision of a physician. Any such drugs dispensed will be labeled to show the identity of the facility, date, directions to the patient, name of drug unless prescriber directs otherwise, and the name of patient and prescriber.

7–5. Therapeutic Agents Board. Rapid advances in the development of new drugs and the vast number of therapeutic agents available to a physician or dentist require the establishment of local control and evaluation procedures, in order to ensure that only the most efficacious and economical therapeutic agents are accepted for use in Army MTF. The Therapeutic Agents Board provides a method which will accomplish this objective, and which will support and enhance high drug standards and the practices of the professional staff.

a. Establishment. A Therapeutic Agents Board will be appointed by the commander of each hospital providing patient care.

b. Composition. Boards appointed at hospitals will be composed, to the extent that personnel and organization permit, of officers to include the Chiefs of Professional Service, Department of Medicine, Department of Surgery, Department of Psychiatry and Neurology, Department of Hospital Clinics, Department of Pediatrics, Department of Obstetrics and Gynecology, Department of Nursing, Department of Dentistry, Pharmacy Service, and Logistics Division. Other officers may be appointed to serve as members.

c. Purposes. The primary purposes of the Therapeutic Agents Board are as follows:

(1) *Advisory.* The board recommends the adoption of assists in the formulation of broad professional policies regarding evaluation, selection, procurement, distributions, use, safe practices, and other matters related to therapeutic agents.

(2) *Educational.* The board recommends or assists in the formulation of programs designated to meet the needs of the professional staff for complete, current knowledge on matters related to therapeutic agents and their use.

d. Functions. The functions of the Therapeutic Agents Board are to—

(1) Advise the commander and the professional staff in all matters pertaining to the use of therapeutic agents.

(2) Advise the commander, the Chief, Pharmacy Service, and the professional staff in the selection or choice of therapeutic agents which meet the most effective therapeutic quality standards.

(3) Evaluate objectively clinical data regarding new therapeutic agents proposed for use in the hospital. The requests for new therapeutic agents will be submitted to the Therapeutic Agents Board on DD Form 2081 (New Drug Request).

(4) Prevent unnecessary duplication in stockage and use of the same basic therapeutic agent or its combinations.

(5) Develop an automated formulary of therapeutic agents for use in the hospital and to provide for its continual review and revision. Such consideration as is necessary will be given the program-budget impact as an adjunct to the professional evaluation as therapeutic agents are added or deleted from the hospital formulary. The relative costs of therapeutic agents producing similar therapeutic action will be considered prior to their inclusion and/or continuation in the hospital formulary. The Master Formulary Data Base maintained by US Army TRIMIS Agency, Walter Reed Army Medical Center, WASH, DC 20012 will be used to develop the individual MTF formulary.

(6) Propose educational programs for the professional staff on particular matters related to therapeutic agents and their use.

(7) Recommend to The Surgeon General nonstandard therapeutic agents considered worthy and desirable for standard-type classification. Recommendations for standard-type classification will include pertinent information such as nomenclature, trade name, source of supply, proposed use and comparable standard items, and the reasons or a type classification, particularly if similiarly acting therapeutic agents are already included in FSC C6505-IL.

(8) Review a summary furnished by Chief of Pharmacy Service of the FSC 6505 notices in the Army Supply Bulletin 8–75 series and disseminate all petinent information to members of the professional staff.

(9) Review all reported adverse drug reactions and forward the appropriate Drug Experience Report (FD–1639) to the Bureau of Medicine, Food and Drug Administration, 200 C St. SW, WASH WC 20204, with a copy fur-

nished HQDA (DASG–HCC–P), WASH DC 20310.

e. Meetings. Boards will meet as often as required, but no less frequently than quarterly.

f. Records. Therapeutic Agents Boards will keep minutes of their meetings. A copy of the minutes of each Therapeutic Agents Board meeting and a copy of each revision of the formulary will be forwarded to HQDA (DASG–HCC–P) WASH DC 20310 and Commander, USAMMA–L, Frederick, MD 21701. Additionally, hospitals under the command jurisdiction of the US Army Health Services Command will also forward a copy of the minutes of each Therapeutic Agents Board meeting and a copy of each revision of the formulary to HQ, US Army Health Services Command, HSPA–C, Ft. Sam Houston, TX 78234.

7–5.1 Therapeutic dietary supplements. *a.* Therapeutic dietary supplements are specially manufactured formulas used in many instances as the sole source of nutrition for patients and are considered therapeutic agents subject to review by the Therapeutic Agents Board (TAB) and approval by the MTF commander. Cost of therapeutic dietary supplements for inpatients and outpatients will be charged to the operating budget of the MTF Pharmacy Service.

b. Inpatients will be provided these items consistent with appropriate professional care as directed by a physician or dentist. For inpatients, food service will be responsible for the storage, preparation, and distribution of these items except that if any medication is added the preparation will be done by the pharmacy service.

c. Outpatients will be provided these items only in exceptional cases which will be reviewed on an individual basis by the Therapeutic Agents Board and approved by the MTF commander. For outpatients, these items will be stored and dispensed by the MTF pharmacy service.

7–6. Controlled substances. "The Controlled Substance Act" (Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970) classifies substances subject to control in five schedules (Schedules I, II, III, IV, and V) according to the abuse potential and psychological and physical effects; establishes rules for their respective control; and provides criminal penalties for violations or prohibited acts in connection therewith. The lists of substances contained in the act are subject to change by the Attorney General, and are required by law to be updated and republished on a semiannual basis from October 1971 to October 1973, and annually thereafter. Items described below, designated and handled as Schedule II substances, are listed as Note "R" items and items designated as Schedule III, IV, or V substances are listed as Note "K" items in the Federal Supply Catalog.

a. Schedule I substances. Drugs in this schedule are those that have no accepted medical use in the United States. Some examples are heroin, marihuana, LSD, peyote, mescaline, psilocybin, tetrahydrocannabinols, Ketobemidone, levomoramide, racemoramide, bensylmorphine, dihydromorphine, morphine methylsulfonate, nicocodeine, nicomorphine, and others.

b. Schedule II substances. Drugs in this schedule have a high abuse potential with severe psychic or physical dependence liability. Most of the Schedule II substances have been known in the past as Class A Narcotic Drugs. Non-narcotic substances are currently included in this schedule. Some examples of Schedule II substances are amphetamines, methamphetamines, methylphenidate, phenmetrazine, opium, morphine, codeine, dihydromorphinone, methadone, pantopan, meperidine cocaine, anileridine, oxymorphone, amobarbital, pentobarbital, secobarbital, and any other substances so designated by amendments to the Controlled Substances Act. Ethyl alcohol and alcoholic liquors, although not included in any schedule of the Controlled Substances Act, will be received, accounted for, and dispensed in the same manner as Schedule II substances.

c. Schedule III substances. The drugs in this schedule have an abuse potential less than those in Schedules I and II, and include those

drugs formerly known as Class B narcotics; and, in addition, nonnarcotic drugs such as glutethimide, methyproylon, chlorhexadol, phencyclidine, sulfondiethylmethane, sulfonmethane, nalorphine, and any other items so designated by amendments to the Controlled Substances Act.

d. Schedule IV substances. The drugs in this schedule have an abuse potential less than those listed in Schedule III, and include drugs such as barbital, phenobarbital, methylphenobarbital, chloral betaine, chloral hydrate, ethchlorvynol, ethinamate, meprobamate, paraldehyde, pentaerythritol chloral, methohexital, and any other items so designated by amendments to the Controlled Substances Act.

e. Schedule V substances. The drugs in this schedule have an abuse potential less than those listed in Schedule IV, and consist of those preparations formerly known as exempt narcotics, with the exception of paregoric. Paregoric is now listed as a Schedule III controlled substance.

★7–7. Individuals authorized to write prescriptions. *a.* The following categories of personnel are authorized to write prescriptions.

(1) *Medical, Dental,* and *Veterinary Corps* officers and civilian physicians, *dentists, podiatrists* on duty at uniformed services medical treatment facilities (MTFs).

(2) Uniformed *podiatrists* who are engaged in professional practice.

(3) *Licensed civilian physicians, dentists,* and *podiatrists,* for personnel eligible for military medical care, subject to the provisions of paragraph *c* below.

a.1. The following personnel are authorized to write prescriptions only for selected medications which have been recommended by the Therapeutic Agents Board, reviewed by the Credentials Committee (AR 40–66) and the physician charged with the direction of the clinical activities concerned, and approved by the MTF commander.

(1) Uniformed *optometrists* and civilian *optometrists* on duty at uniformed services MTFs who are engaged in professional practice. Optometrists will not prescribe controlled substances.

(2) *Other* health care providers. This category of personnel is not authorized to write prescriptions for controlled substances except under conditions stated in (*a*) through (*d*) below.

(*a*) Uniformed and civilian *nurse practitioners* and *nurse midwives* and uniformed *clinical nurse specialists* with additional skill identifiers are authorized to prescribe the following controlled substances: Butalbital, aspirin, caffeine and phenacetin (Fiorinal) tablets; diphenoxylate hydrochloride and atropine (Lomotil) tablets.

(*b*) *Graduate physician assistants* may prescribe up to a maximum of 20 tablets of the controlled substance diphenoxylate and atropine (Lomotil) only for active duty personnel. These prescriptions will be refillable.

(*c*) *Enlisted medical corpsmen* (AMOSISTS) functioning within the limits of the AMOSISTS program may be authorized by the MTF commander to write prescriptions for selection medications. They will only be authorized to write prescriptions for those medications which are delineated in logic flow charts developed and prepared by the Academy of Health Sciences (AHS) and adapted by the supervising physician of an AMOSIST program.

(*d*) *Physical therapist* and *occupational therapist* may write prescriptions for aspirin, phenacetin and caffeine (APC), and acetaminophen (Tylenol).

(*e*) *Graduate physician assistants, AMOSISTS, physical* and *occupational therapists, nurse practitioners, clinical nurse specialists,* and *nurse midwives* are not authorized to write prescriptions for psychiatric controlled substances. (However, the latter three may request exception to this policy as explained below.) This restriction includes all antidepressant drugs and anti-anxiety drugs such as phenothiazines and benzodiazepines. Requests for exception will be submitted to The Surgeon General, Department of the Army, ATTN: DASG–PSC, WASH DC 20310. Requests for exception will be accompanied by a protocol acceptable to the Chief of Neuropsychiatry and the Credentials Committee at the MTF concerned. *Community health nurses* who are functioning under a protocol acceptable to the Chief of Pulmonary Disease or Chief of Internal Medicine

and the Credentials Committee may write refill prescriptions for isoniazid and pyridoxine. In addition, while working under the direct supervision of the Chief, Pediatric Department, they may be authorized to write prescriptions for Gamma benzene hexacholoride shampoo.

b. Prescriptions written by licensed civilian physicians, osteopaths, dentists, or podiatrists for personnel eligible for military medical care will be honored at Army MTFs subject to the availability of pharmaceuticals and personnel. Filling a prescription written by a civilian practitioner does not imply knowledge of or responsibility for a patient's medical condition. Under no circumstances will civilian prescriptions be countersigned by military practitioners. Local policy relative to filling such prescriptions will be established and announced by the commander. Policy will relate to, but not be restricted to, matters such as professional responsibility and requirement to determine authenticity and accuracy of the prescription, methods of proving eligibility for prescription services, and any limitations or other rules regarding refills and amounts to be dispensed. Policy for filling civilian prescriptions and those written by staff authorized prescribers should coincide except that in those MTFs located in any State where product selection by the pharmacist is not authorized, the generic equivalent will not be substituted for a brand name drug on a civilian prescription without prior approval of the prescriber. A distance factor or geographic boundary limitation will not be the reason for the denial of prescription services.

c. Personnel described in *a* and *a.1* above are not authorized to prescribe Schedule II controlled substances for themselves or members of their families.

d. Graduate physician assistants may, when authorized by the commander, dispense those drugs which they are authorized to prescribe when functioning in a troop medical clinic setting.

7–8. Signatures. *a.* Except as provided in *b* below, no prescription or order will be filled in the pharmacy unless it bears the signature of an individual authorized to write prescriptions. Personnel assigned to duty in the pharmacy will keep themselves familiarized with the signatures of individuals authorized to write prescriptions to guard against possible forgeries. When prescriptions received in the pharmacy are not legible or there is a question regarding authenticity of the prescription, dosage, compatibility, or directions to the patient, clarifications will be obtained from the prescriber prior to dispensing the medications.

b. Subject to such restrictions as may be prescribed locally by the commander, the pharmacy will honor bulk drug orders for drugs other than controlled substances when signed by a designated representative of the officer in charge of the using agency, provided the pharmacy is first furnished in writing the name and autograph signature of each designee.

c. Orders for items for which a stock record must be maintained will be signed by individuals authorized to write prescriptions or a registered nurse.

7–9. Dispensing. *a. General.* The pharmacy will serve as the source of supply from which wards, clinics, other agencies of the facility, or satellited activities normally will obtain drugs and medicinals as required. In addition, the pharmacy dispenses directly to inpatients and outpatients such preparations as may be authorized and required.

b. Prescription forms. Prescription form DD Form 1289 (DOD Prescription) is to be used when only one item is prescribed. Commanders of MTFs may authorize the use of a locally developed multiple prescription form on an interim basis until either a DA or DD Form is published. Prescription blanks provided by or preprinted by a commercial company will not be used in an Army MTF; however, a rubber stamp or addressograph plate may be used on DD Form 1289 for commonly prescribed items. Information pertaining to drug manufacturer, lot number and expiration date is not required on any DD Form 1289 written in an Army MTF if there is a drug recall procedure that can be readily implemented.

c. Bulk drug orders. DA Form 3875 (Bulk Drug Order) will be used for ordering from the pharmacy all drugs or preparations in bulk quantities for use in a ward, clinic, or other except

those drugs or preparations for which a stock record is maintained under paragraph 7–16.

d. Procedures.

(1) Items for which a stock record must be maintained will be dispensed only upon receipt of a properly written and authenticated prescription. The DD Form 1289 will be used as an order form for purposes of ordering stock record items from the pharmacy in bulk quantities.

(2) Potentially harmful drugs will be dispensed only upon receipt of a properly written prescription or bulk drug order. Included in this category are all drugs, whether for internal or external use, which are habit forming, or have toxic or other potentially harmful effects, or because the method of their use or the collateral measures necessary for their use, are not safe for use except under the supervision of a practitioner licensed by law or authorized by regulations to administer such drugs as provided in the

Food, Drug, and Cosmetic Act, as amended. Any drug which is subject to control under the provisions of the "Controlled Substances Act of 1970" will only be dispensed by a graduate licensed pharmacist, a dispensing physician, or a dispensing dentist.

(3) All other items will be dispensed in accordance with regulations prescribed by the commander and will be properly labeled to show the purpose for which they are to be used and will bear the legend "KEEP OUT OF THE REACH OF CHILDREN." Within the discretion of the commander, individual MTF are permitted to establish hand out programs of nonprescription medications with the programs being strictly defined and controlled as to both medications included and quantities to be dispensed. Items so dispensed will be limited to inexpensive, nonhazardous over-the-counter medications for simple conditions like headaches, mild indigestion, mild dermatitis and the common cold. Quantities of drugs will be limited to one complete regimen or a few days supply. Medications dispensed under this program should include printed instructions for use, contraindications, when to seek further care, and other material as appropriate. The program should be explicitly designed to reduce the utilization of alternatives more expensive to the medical facility, the AMEDD, or the patient. Adequate supervision will be exercised over such programs to prevent abuse and records will be kept to show patient's name, drug, date, and amount dispensed.

7–10. Prescription writing. *a.* Prescriptions will be stamped, typed, or written in ink and will be signed in ink by an authorized prescriber.

b. Prescriptions shall be dated as of, and signed on, the day when written and shall bear the full name and address or telephone number of the patient except that all prescriptions for controlled substances must, by Federal law, contain the patient's address. When patients present more than one prescription for other than controlled substances, the full name must be on all, with the address or telephone number on at least one of the prescriptions.

c. Individuals authorized to prescribe, dispense, and administer controlled substances, in the course of their official duties, are exempt from the requirements to have a Drug Enforcement Agency registration number. They shall include on all prescriptions for controlled substances issued by them their signature, branch of service, service identification number (social security number) in lieu of the registration number, and their name stamped, typed, or hand printed. Any person who engages as a private individual in any activity or group of activities for which registration is required shall obtain a Drug Enforcement Agency registration for such private activities. A list of SSN's of authorized prescribers assigned to the MTF will be maintained by the pharmacy service.

d. On all prescriptions for children 12 years of age and under, age is recommended.

e. It is recommended that prescriptions originating in Army MTF be written using the metric system. The vertical line on the prescription blank is considered to be a decimal point for this purpose.

f. It is recommended that on prescriptions for controlled substances, the amount prescribed should be shown both in numerals and spelled out in words.

★*g.* Prescriptions written by nurse practitioners/clinical nurse specialists nurse midwives, community health nurses, graduate physician assistants, physical therapists, or AMOSISTS must bear the typed, stamped or printed statement "to be filled only at (name of local MTF) pharmacy."

h. Prescriptions written by civilian or military veterinarians listed in paragraphs 7-7*a*(1), (3), and (4) will be honored at an Army MTF only for Government-owned animals. Prescriptions for privately-owned animals will not be filled in an Army MTF (AR 40-905).

i. A system designed to assure accurate identification of outpatients at the time they receive prescribed medications will be established.

7–11. Mailing of prescriptions. The decision to mail prescriptions to patients will be the prerogative of the MTF commander. Each situation will be evaluated on an individual basis with consideration given to the patient's unique needs; the availability of space and facilities; and any restrictions imposed by law or regulation. Based on these parameters, the commander may authorize the mailing of prescriptions in unusual cases. In all cases, an individual's eligibility and entitlement to prescription services will be ascertained prior to the filling and mailing of any prescriptions. Narcotic drugs will not be mailed. If other controlled substances are mailed, certified mail will be utilized with a return receipt requested.

7–12. Refilling prescriptions. *a. Schedule II pre-*

scriptions. Refilling prescriptions for Schedule II controlled substances, ethyl alcohol, and alcoholic liquors is prohibited. These items are designated as Note "R" in the Federal Supply Catalog.

b. Schedule III through Schedule V controlled substances or other potentially harmful drugs.

(1) Prescriptions for Schedule III through Schedule V controlled substances and any other drug designated by the commander will not be refilled unless such refilling is authorized by the prescriber in the original prescription.

(2) Prescriptions for those drugs will not be renewed more than five times and will not be renewed more than 6 months after the date of issue.

(3) When a prescription for any controlled substance in Schedule III through V is refilled, the pharmacist will enter his initials, the date of the refilling and the amount of the drug refilled on the back of the original prescription form or on another appropriate uniformly maintained record which indicates prescription refills.

(4) Schedule III through Schedule V controlled substances are designated as Note "Q" in the Federal Supply Catalog.

c. Other prescriptions. Prescriptions for all other drugs and medicines may be refilled to the extent authorized by the commander. When refilled, the pharmacist will enter his initials, the date of the refilling, and the amount of the drug refilled on the back of the original prescription or the same information to include the prescription number may be recorded on another appropriate uniformly maintained record which indicates prescription refills.

7–13. Accounting for controlled substances used in the manufacture of pharmaceutical preparations. Prescription forms with the symbol R_x lined out will be used to account for all controlled substances used in the manufacture of pharmaceutical preparations. Such orders will be authenticated and signed by the officer in charge of the pharmacy and be filled in the appropriate prescription file.

★7–14. Labeling. *a.* A label will be prepared for each prescription dispensed to individuals and will be securely affixed to the container prior to dispensing. The label will show as a minimum—

(1) Identity of facility, to include telephone number of pharmacy.

(2) Prescription number.

(3) Name of prescriber.

(4) Directions to the patient.

(5) Name and strength of drug, except when prescriber directs otherwise.

(6) Name of the patient with first and last name spelled out.

(7) Initials of person typing the prescription label.

(8) The legend "KEEP OUT OF THE REACH OF CHILDREN" on all prescription labels.

(9) The Uniform Chart of Account (UCA) Code described in DOD Manual 6010.10M.

(10) The legend "CAUTION: FEDERAL LAW PROHIBITS THE TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM IT WAS PRESCRIBED" on all labels for controlled substances as defined by Federal Law.

b. Any necessary supplemental labels warning individuals of potentially dangerous drug interactions with alcohol, other drugs, certain foods and certain side effects in accordance with the sound professional judgment exercised in the practice of pharmacy.

c. Labeling requirements for drugs issued in bulk to wards, clinics, and other authorized agencies will be prescribed by the commander. Drugs, other than prescriptions, dispensed to individuals will be labeled as provided in paragraph 7-9*d*(3).

d. When the contents of a prescription are for external use only, in the case of liquid preparations, or require further preparations for use (shaking, dilution, adjustment of temperature, or other manipulation or process), appropriate directions will be included on the label, or an additional label appropriately printed will be affixed to the container. In the event liquid preparations for external use are poisonous, a "poison" label will be affixed thereto. When medicines prescribed for internal use are of a poisonous nature, the pharmacist will use sound judgment as to the advisability of labeling the preparation "poison" considering in each case the potency of the finished preparation.

e. Medicinal preparations compounded or repackaged in the pharmacy for subsequent issue to wards or clinics will be identified and labeled with the full generic name, except that trade or brand names may be used provided the trade or brand name product actually is in the container. The manufacturer's name, lot number, and expiration date, if any, will be shown on the label of all commercial products which are repackaged.

f. Intravenous solution admixtures prepared by

the pharmacy service will be labeled as follows:

(1) Patient's name and location.

(2) Serial number or prescription number of the solution.

(3) Generic name(s) of drug(s) added and amount.

(4) Basic solution.

(5) Date and time to start administration.

(6) Date and time to be discarded.

(7) Refrigeration instructions (if applicable).

(8) Initials of person who prepared solution.

g. The Armies of the United States, United Kingdom and Australia and the Canadian Forces have agreed to use supplementary labels for dispensed medicines within a wartime theater of operations in which members of two or more participating armies are deployed (see app B).

★ **7–15. Numbering and filing.** All prescriptions and orders filled by the pharmacy will be placed in files established and maintained in the pharmacy. Prior to filing, prescriptions will be numbered serially, checked to insure UCA Code is shown, and initialed by the person who filled them. Three or more series of numbers will be used; i.e., one series for Schedule II controlled substances, alcohol, and alcoholic liquors; one series for Schedules III, IV, and V controlled substances; and one series for all others. A corresponding file will be established for each series of numbers.

7–16. Stock record. *a.* The pharmacy will maintain a record of receipts and expenditures of all controlled substances, ethyl alcohol and alcoholic liquors, and of such other drugs as may be designated by the commander. A separate record will be maintained on DA Form 3862 (Controlled Substances Stock Record) for each form in which the item is supplied.

b. Scheduled II controlled substances, ethyl alcohol and alcoholic liquors. When an item is received, the date, the quantity received, and the voucher number will be entered in the appropriate columns. Similarly, when stock is withdrawn, the date expended, the prescription or order number, and the amount expended will be entered. At the time the entry is made on the card, whether it be a receipt or expenditure, the amount involved will be added to or subtracted from, as appropriate, the amount shown in the "Balance on Hand" column. The new figure will always reflect the actual amount on hand.

c. Schedules III, IV, and V controlled substances and any other items designated by the commander. When an item is received, the date, the quantity received, and the voucher number will be entered in the appropriate columns. Expenditures for each item will be summarized weekly and posted to the DA Form 3862. Within the guidance established by the local commander, an adjustment for minor overages and shortages caused by operational handling or undiscoverable posting errors will be made by posting an inventory adjustment to the stock record. All major inventory shortages will be investigated immediately and remedial action taken.

d. Items designated by the commander as controlled drugs may include drugs which have an abuse potential and expensive items known to be readily saleable on the civilian market. Special security and accounting procedures for command sensitive items designated as controlled drugs will be established by the local medical commander.

e. The metric system will be used for all entries where appropriate.

f. At least once each month a disinterested officer, senior noncommissioned officer, or DA civilian, grade GS–7 or above, will be designated by the commander to inspect the stock records for the controlled substances. The individual will conduct an inventory for each item included in *b* above and check the amount of each drug or preparation actually in stock against the figure shown on the stock record card and spot check stock records with regard to receipts, expenditures, and mathematical accuracy as determined by the local commander. The findings, together with the date of the inspection and the action taken, will be noted over his signature and grade immediately below the last entry on the card. Concurrently, an inspection of at least 33 percent of the items in *c* above will be conducted and a written report forwarded to the commander, noting any unusual expenditures or discrepancies. All items in *c* above will be inspected at least quarterly.

g. Records and supporting vouchers reflected in *a* above will be retained for a period of 5 years after the date of last posting to provide an audit trail, when required.

h. Safeguarding and storage of controlled substances will be in compliance with provisions of the Comprehensive Drug Prevention and Control Act of 1970. At least annually, the installation provost marshal will be requested to survey the adequacy of

security provided, and corrective action will be taken where indicated.

7-17. Destruction of drugs, biologicals, and reagents determined to be unsafe or unsuitable for issue. *a.* Controlled substances (para 7-16) which have deteriorated to the point where they are not usable for the purpose originally intended, are of questionable potency, or have had their identity compromised, will be reported to the commander for a determination of disposition. Commanders will take such action as may be appropriate and, when indicated, will investigate negligence or carelessness and will direct appropriate disposition of the reported items. If destruction is directed, destruction will be accomplished in the presence of a witnessing officer and such other officials as may be required by regulations (AR 40-61). A record of such destruction, signed by the witnessing officers, will be filed in the controlled substances file as authority for dropping the items from the records of the accounts.

b. Noncontrolled substances determined to be unsafe or unsuitable for issue in unit of issue quantities will be turned in to the chief, supply and services, for destruction in accordance with DOD 4160.21-M. Destruction of less than unit of issue quantities will be accomplished in accordance with local policy established and announced by the commander.

7-18. Inspection and disposition of prescription files and records. *a. Inspection.* Prescription and allied records will be subject to inspection by inspectors and higher echelon commanders at all times.

b. Disposition. Prescription files, narcotic records, and other records maintained in the pharmacy will be retained and disposed in accordance with AR 340-18-9.

7-19. Investigational drugs. *a. Definition.* An "investigational drug" is defined as a new drug, not yet approved by the Commissioner of Food and Drugs, Department of Health, Education, and Welfare (FDA) for general use by the public as a safe and efficacious drug.

★*b. Request for approval.* No investigational drug will be used without the prior written approval of The Surgeon General. Requests for approval to use investigational drugs will be prepared and submitted to Assistant Surgeon General for Research and Development (ATTN: SGRD-HR) WASH DC 20310 in accordance with the provisions of AR 40-7.

7-20. Standards for medical agents. *a.* No new drug will be administered to patients under the care of the AMEDD until it has been approved by the Federal Food and Drug Administration for commercial sale and use, except as provided in paragraph 7-19*b*. The term "drug" as used in this regulation does not include biological products.

b. No biological product which has not first met one or more of the following conditions will be administered under the care of the AMEDD:

(1) Included in *Federal Supply Catalog C-6505/6508-IL.*

(2) Approved or recommended for use in Department of the Army official publications.

(3) Specially approved by The Surgeon General.

c. Approval authority for the procurement and use of drugs not included in *Federal Supply Catalog C-6505/6508-IL,* but which fulfill the requirements cited in *a* above, is delegated to the following commanders and surgeons, who may further delegate this authority:

(1) Commanding General, US Army Health Services Command.

(2) Chief Surgeons of major oversea commands.

★*d.* Commanders of Army MTF, not included under the command jurisdiction of those commands enumerated in *c* above, will in each instance request approval for procurement and use of any drug not included in the United States Pharmacopoeia, National Formulary, or *Federal Supply Catalog C-6505/6508* from HQDA (DASG-PSP-P), WASH DC 20310. Requests for approval to use new drugs for investigational purposes will be submitted as prescribed in paragraph 7-19*b*.

CHAPTER 8

CONTROLLED SUBSTANCES REGISTER

8–1. General. *a. Description.* The Controlled Substances Register is a looseleaf notebook for the centralized filing of ward records pertaining to receipts, issues, balances, and audits of all controlled substances for which nursing service personnel are responsible. This register, which will be available only to authorized personnel, will be kept in the nursing office on the ward and will account for—

(1) Those drugs listed in Schedules II through V, paragraph 7–6.

(2) Any other drug not shown above which may be designated by the MTF commander.

b. Forms. The following forms will be maintained for the register:

(1) Controlled Substances Inventory (DA Form 3949–1).

(2) Controlled Substances Record (DA Form 3949).

c. Administration. Any ward using a unit dose drug distribution system may deviate from the requirements of this chapter if the record keeping system utilized for the ordering, receipt, and administration of controlled substances will provide a complete audit trail of accountability for the drug to and including administration to the patient.

8–2. Maintenance of register. The register will be divided into two major sections by indexed divider sheets. One major section will be for Note "R" controlled substances. Note "R" items refers to those substances which are classified as Schedule II and defined in chapter 7 of this regulation along with ethyl alcohol and alcoholic liquors. They are listed as Note "R" items in the Federal Supply Catalog. The other major section will be for Note "K" controlled substances which refers to those items classified as Schedule III, IV, and V as defined in chapter 7 of this regulation. They are listed as Note "K" in the Federal Supply Catalog. Any other items designated by the commander to be controlled may be classified as either Note "R" or Note "K" with reference to record keeping requirements and this determination will be made by the commander. Each of the two major sections of the register will be arranged such that Controlled Substances Inventory (DA Form 3949–1) will be filed in the front followed by a separate Controlled Substances Record (DA Form 3949) for each controlled substance covered by this regulation that is stocked on the ward. The Controlled Substances Records will be arranged in sequence to correspond with the order in which drugs are listed on the controlled substances inventory and will be filed behind divider sheets appropriately marked to denote the controlled substance.

8–3. Instructions for use of register. *a. Controlled Substances Inventory.* At the completion of each tour of duty, the registered nurse, civilian licensed practical nurse, or clinical specialist coming on duty will effect transfer of the possession of controlled substances by making a joint inventory of such items on hand and comparing the amounts on hand with the balances shown on DA Form 3949. Such transfer will only be effected by a civilian licensed practical nurse or clinical specialist when a registered nurse is not assigned for that tour of duty. If correct, the balance on hand will be recorded in the appropriate column on DA Form 3949–1, and the signatures of the authorized persons effecting the exchange entered in the appropriate space. Discrepancies will be reported immediately upon discovery to the next higher authority.

b. Controlled Substances Record. The box headings of each DA Form 3949 will be completed to reflect the ward number, date, correct name of the drug, accountable unit of measure, and balance on hand.

(1) *Drug expenditure entries.*

(*a*) Each time a drug is dispensed, complete information will be recorded as to the disposition of the drug. The day, hour, patient's name, initial and last name of the doctor who ordered the medication, signature of individual administering the drug, and the accountable unit of the drug dispensed will be entered. The amount expended then will be subtracted from the amount shown in the "Balance" column on the line above and the new balance recorded in the "Balance" column. In cases where the accountable units are designated as milliliters (cubic centimeters) the amount used will be recorded as a decimal portion of the unit.

(*b*) In those cases where the unit administered is a fractional dose of the whole unit(s) dispensed, the unit administered will be placed in parentheses before the number of units in the "Expenditures" column (e.g., "(.010) 1" indicates that one tablet of morphine sulphate, 0.016 gm. was administered, or "(.010) 2" indicates that of two tablets, morphine, 0.008 gm. expended, only 0.010 gm. was administered).

(*c*) If a unit of a controlled substance is accidentally destroyed, damaged, or contaminated during preparation for administration, a record of the fact will be made on the Controlled Substances Record, including the date, amount of drug, brief statement of the circumstances, the new balance, and the signature of the person making the entry.

(2) *Drug receipt entries.* When controlled substances are issued to a ward, the pharmacy representatives will record on each appropriate form, the day, hour, amount of drug, and new balance. The pharmacy representative will enter his signature in the "Administered by" column. The receiving authorized person will acknowledge receipt of the drug by placing her initials in the "Expenditures" column on the same line as the pharmacy entry and by signing the prescription form used to request the drug.

(3) *Correction of errors.* Erasures and eradications invalidate records and such methods will not be used to correct errors in the register. Errors will be corrected by a single line, in ink, drawn through the erroneous entry and initialed by the person making the correction. The correct entry will be recorded on the following line if necessary.

c. Audit procedures. At least once each month a disinterested officer, senior noncommissioned officer, or DA civilian, grade GS–7 or above, will be designated by the commander to inventory the controlled substances and audit the Controlled Substances Register. All controlled substances on hand, will be inventoried and audited each month. The individual performing the audit will record the day and hour, enter the statement "checked and found correct," or other appropriate statement, and sign his name and grade making these entries on the next unused line on both DA Forms 3949 and 3949–1 at the time of the audit.

8–4. Use by specialty clinics. The Controlled Substances Record, DA Form 3949, will be utilized by specialty clinics which have controlled substances and will be maintained, to the extent feasible, in accordance with the procedures for using this form stated in paragraph 8–3.

8–5. Disposition of records. Controlled Substances Inventory and Controlled Substances Records will be disposed of as prescribed in AR 340–18–9.

CHAPTER 9

HOSPITAL FOOD SERVICE

★**9–1. Purpose and scope.** This chapter prescribes policies and procedures for the operation of hospital food service in fixed medical treatment facilities (MTFs).

★**9–2. Manner of providing food service.** Food service will be provided through the media and in the priority listed below:

a. Operation of hospital food service within the facility. This type of operation should not be identified with field ration and monetary allowance ration system dining facilities governed by AR 30–1. Hospital food services are to be operated for the primary purpose of feeding inpatients, when the number of inpatients justify the operation. When the number of inpatients do not justify the operation of hospital food service, the feasibility of providing subsistence by means set forth in *b* below will be explored. The authority for nonpatient personnel to subsist in the hospital food service (para 9–6) must be economically justifiable or it must be obviously unfeasible for such personnel to subsist by other means. In some instances it may be advisable to authorize subsistence allowances in lieu of furnishing rations in kind.

b. In unusual circumstances where, because of the relatively small operational activity of the hospital or medical center and or its isolated location, it has been determined by the commander and approved by the major commander concerned to be more economical not to operate a hospital food service, food service for patients will be provided from the following sources in order of priority stated:

(1) Existing field ration dining facilities.

(2) Officers and noncommissioned officer's messes.

(3) Post restaurants.

(4) Commercial eating establishments or private individuals.

9–3. Mission. The mission of the hospital food service is to provide comprehensive nutritional care to provide safe, wholesome foods including, as appropriate, special diets, to patients and other personnel authorized to subsist in the hospital food service facilities; dietary counseling for patients; the provision of nutrition education for the military community; and applied research.

9–4. Organization and functions. The organization and functions of hospital food services will be as prescribed by the major commander having jurisdiction over the hospital or medical center.

★**9–5. Definitions and application of terms.** For the purpose of this chapter the following definitions and applications of terms apply.

a. Hospital ration. The "hospital ration" is subsistence furnished by the hospital food service to an individual during a 24-hour period (0001 to 2400). Since it is a term employed exclusively in hospital food service operations, it is not to be confused or identified with garrison, field, or other special type rations described in AR 30–1.

b. Allowance. Monetary allowance for hospital subsistence will be established on a daily basis. This allowance for subsistence is established to provide a "yardstick" for controlling the monetary value of food required.

c. Breakfast. The meal served during the morning hours and considered the first meal of the day.

d. Lunch. The meal served during midday and considered the second meal of the day.

e. Dinner. The meal served during the evening hours and considered the third meal of the day.

f. Brunch. The meal served in lieu of the normal breakfast and lunch meals and consisting of both breakfast and lunch food items.

g. Dinner brunch. The meal served during the evening hours on days when brunch is served.

h. Night meal. The "night meal" is the meal served during late evening to early morning hours. This meal will be counted as a meal served on the day the night meal serving period commences.

★**9–6. Persons authorized to eat in hospital food service facilities.** The hospital food service is established to provide meals for patients and duty enlisted personnel, except when they are entitled to a basic allowance for subsistence or per diem instead of subsistence. At his discretion, the commander may authorize other personnel assigned or attached to the MTF or other guests to subsist in

the hospital dining facility on a regular basis or for occasional meals. When other personnel or guests are authorized to subsist in a hospital food service facility, special menus or service will not be provided. Separate dining areas will not be established when it will cause an inconvenience to patients or enlisted personnel authorized subsistence-in-kind. Adequate administrative controls will be established to insure prescribed reimbursement for all meals and/or subsistence items consumed. A locally unique meal card may be developed to identify authorized personnel and guests by category as identified in paragraph 9-11*a*. The card should provide ready identification to the cashier of those individuals for whom per diem rates are in effect. Subsistence charges will be collected in accordance with applicable directives. Payment for subsistence will normally be made in cash. Payroll deductions for subsistence furnished to civilian food handlers will be utilized only when cash collection is not feasible. See paragraph 19-44*d*, AR 37-105.

★**9–7. Responsibility.** *a.* Commanders at all echelons are responsible for providing nutritionally adequate diets within the established local monetary value of the hospital subsistence allowance to patients and personnel subsisting in hospital food service facilities, and for insuring the sanitary quality of the subsistence.

b. The Chief, Food Service Division, is responsible to the commander for operating all food service activities efficiently and economically, planning and controlling the overall operation of the division, and exercising positive and continuous supervision over all phases of food preparation. Sanitary requirements which must be followed are contained in TB MED 530 (to be published). Commanders will be guided by the fact that subsistence is government property until such time as it is consumed. Subsistence procured by appropriated funds and issued to the dining facilities will not be used to support social functions. Like other Government property, subsistence will be safeguarded during receipt, storage, issue, preparation and service. The commander will establish internal controls to adequately protect subsistence supplies and insure that accurate food service accounting records are maintained. The Chief, Food Service Division, will—

(1) Review and analyze current work methods to improve and simplify operations procedures.

(2) Initiate control measures to effect economical and effective utilization of manpower, equipment, supplies, and funds.

(3) Insure that proper standards of sanitation, safety, and security are maintained within the division.

(4) Insure proper dietetic treatment of patients as prescribed by medical and dental officers.

(5) Insure that a meal attendance headcount is taken for each meal served and a collection system is established to collect funds in payment of subsistence consumed.

(6) Insure that the food service division meets or exceeds those standards set forth by the Joint Commission on Accreditation of Hospitals.

c. The medical service accountable officer will account for funds turned over to him/her for payment of subsistence in accordance with AR 40-335.

★**9–8. Personnel management.** Assignment of duties and responsibilities to positions; establishment of a structure of positions and their relationship to each other within an approved functional organization; and allotment of spaces required will be directed toward achieving labor cost economy and efficient personnel management.

a. Work schedules. The work day for food service personnel shall coincide with the calendar day (0001-2400). To provide an adequate number of employees to maintain a high efficiency of food service activities during the 18-24 hour operation 7 days a week with a minimum number of employees, work schedules will be carefully preplanned to reflect even the smallest authorized fluctuation in workload and will provide fair and equitable early and late shifts and off duty time.

b. Training. Establishment and maintenance of a program of training within the Food Service Division is essential to improve work methods and develop potential abilities of individuals. The method of training will be determined by training objectives, training facilities available and the number of personnel to be trained. A record of training for all good service personnel, to include dietitians, will be maintained by the chief, food service division.

★**9–9. Standard hospital diets.** Standard hospital diets based upon TM 8-500 will be prepared and approved by the chiefs of professional services, and made available to physicians, nurses, dietitians and food service supervisors. These standard diets will delineate any nutritional deficiencies

in the diet from those recommended in the Recommended Dietary Allowance (1979) of the Food and Nutrition Board of the National Research Council and shall be reviewed annually by the dietitian and updated as necessary. The date of review and approval of the standard house diets by the medical staff shall be documented.

★9–10. DA Form 1824 (Hospital Food Service—Hospital Master Menu—Part I) and DA Form 1824–1 (Hospital Food Service—Hospital Master Menu—Parts II and III). The hospital menu will be planned to provide nutritionally adequate meals within established monetary limitations. Due consideration will be given to the availability and acceptability of food items and the principles of good menu planning. All foods required for regular as well as modified diets will be preplanned and approved and signed by a dietitian. DA Forms 1824 and 1824-1 will be used in developing the hospital menu.

9–11. Ration accounting. Accurate records of meals served and rations served will be maintained as a basis for determining future requirements for food supplies, as well as providing data for costing, staffing, and reporting purposes.

a. DA Form 1833-2 (Hospital Food Service—Ration Source Data Worksheet). One copy of this form will be completed daily for each dining hall. Figures for ward meals served, line 19, will be provided by clinical dietetics personnel. Categories of nonpatients listed on the form will be accurately identified and reported each meal. Figures for patients served in dining hall, line 17, will be provided by personnel assigned to dining hall headcount. Separate counts of actual meals served will be made for the following categories of nonpatients:

(1) *Staff.* Staff assigned or attached to hosptial duty.

(*a*) Army enlisted staff not on separate rations.

(*b*) Enlisted staff of all other military services not on separate rations.

(*c*) Enlisted staff of all military services on separate rations.

(*d*) Authorized staff officers, civilians, and American Red Cross.

(*e*) Civilian food handlers with payroll meal deductions.

(2) *Guests.*

(*a*) Army enlisted guests not on separate rations (on-the-job trainees, clinic patients, and those held over at mealtime).

(*b*) Enlisted guests of all military services not on separate rations.

(*c*) Enlisted guests of all military services on separate rations.

(*d*) Authorized officer guests, civilian guests, and American Red Cross guests.

(*e*) Reserves of all military services, assigned to the MTF, while on active duty for weekend/annual active duty training.

b. DA Form 1833-1 (Hospital Food Service—Meals Served Record). This record will be posted daily for each dining hall from DA Form 1833-2. Monthly copies will be retained by the kitchen for accurate estimation of daily advance food orders.

c. DA Form 1833 (Hospital Food Service—Ration Record). Columns b through bb of this form will be posted daily from DA Form 1833-2 for each dining hall. Where more than one dining hall is in operation, all figures will be consolidated each day to provide the total rations served for each day of the month. Entries on the form will be made in whole numbers, except for line 33, in accordance with the following:

(1) *Columns b through bb.* Enter the number of meals served to non-patients. The entires in columns c d e, g h i, l m n, p q r, u v w, and y z aa are included in the entries of the preceding columns. For example, columns c, d, e, are included in column b. Night supper meals will be included under breakfast, lunch or dinner as appropriate and as determined by the food service division. On the days a brunch meal is served, columns k through s only will be completed in lieu of using columns b through j, unless an early breakfast meal is served in addition to the brunch.

(2) *Column cc.* Multiply column j by the weight shown on line 33 for breakfast and enter the result. This column will not be completed when a brunch meal is served unless early breakfast is served in addition to the brunch meal.

(3) *Column dd.* Multiply column s by the appropriate weight as shown on line 33 for the lunch or brunch meal as served and enter the result.

(4) *Column ee.* Multiply column bb by the appropriate weight as shown on line 33 for the dinner/brunch meal as served and enter the result.

★(5) *Column ff.* Enter the number of patients in a "beds occupied" status (as defined in app C, AR 40-400) less bassinets.

★(6) *Column gg.* Enter the total number of RON patient rations earned. This figure will be determined by applying the mean conversion factors as established in paragraph 9–11*a*(8) to the meals served to RON on a daily basis. Fractions of rations earned will not be carried forward. If the total rations for the day result in a ration that is .50 or higher, round off to the next higher whole number. If the fraction is lower than .50, drop it.

★(7) *Column hh.* Enter the sums of columns cc through gg.

(8) *Line 33.* Enter the meal conversion factors as follows:

Meal	*Factor*
Breakfast	.20
Lunch	.40
Brunch	.45
Dinner	.40
Dinner/brunch	.55
Night meal	.20 or .40 depending on whether breakfast or dinner meal is served.

In the event an early breakfast is served before brunch, the factors for breakfast, lunch and dinner will be used in lieu of the brunch and dinner/brunch factors.

(9) *Line 34.*

(*a*) *Columns b through i.* Multiply line 32 by the breakfast weight shown on line 33 and enter the result.

(*b*) *Columns k through r.* Multiply line 32 by the appropriate weight as shown on line 33 for the lunch or brunch meal as served and enter the result.

(*c*) *Columns t through aa.* Multiply line 32 by the appropriate weight as shown on line 33 for the dinner or dinner/brunch meal as served and enter the result.

(*d*) *Columns cc through hh.* Enter the sum of lines 1 through 31.

★(10) *Lines 35 through 45.* Line 36 is used to record rations served to RON patients. The entry on line 42 may vary slightly from the entry on line 34, column hh, due to fractional differences. Include line 36 in the total number of rations served to be entered on line 45.

9–12. Subsistence and supply management. Efficient operation of the hospital food service is largely dependent upon adequate control over purchase, inspection, receipt, storage, and issue of food items and general food service supplies. Losses and discrepancies will be immediately investigated and appropriate followup action taken.

a. Food requisitions for troop issue subsistence activity (TISA) and/or installation commissary. All subsistences items for fixed Army hospital and medical centers, including special patient feeding time, will be supplied by the TISA and/or the installation commissary officer in accordance with AR 30–18 and/or AR 30–19. At those installations where there is a fixed Army medical treatment facility and a commissary resale activity, but no TISA, all subsistence requirements will be supplied by the commissary resale activity. Advance food estimates are submitted as requested by the TISA and/or the installation commissary officer. DA Form 3161 (Request for Issue or Turn-in) will be submitted with fund cite by the requisitioning officer.

b. Receipt for food from TISA and/or installation commissary.

(1) Subsistence items will be carefully checked upon receipt. Quantities received will be determined by actual count or weight to insure that they are in agreement with those shown on the invoice, DA Form 3161.

(2) The invoice serves as the basis for food receipt entries on the DA Form 1835 (Hospital Food Service—Food Receipt and Consumption Record). This form will be maintained for all food items other than fresh fruit, fresh vegetables, bread, and dairy product purchases handled in the food service division. The primary purpose of DA Form 1835 is to aid in determining quantities of items to be requisitioned. By reviewing consumption factors, future requirements may be forecast with a greater degree of accuracy. Also, the record serves as a valuable reference and guide since date, voucher, and quantity of receipts are recorded in a chronological manner.

(3) During the month, the quantities of food items received will be posted in column c as of the day received, with the number of the voucher from which the entry was posted.

(4) At the close of the month, a physical inventory of food items on hand will be made and the quantity entered on the line below the last entry in column d. The difference between this inventory figure and the preceding entry in the same column will be entered on the same line adjacent to the inventory figure in column e.

(5) If the cost of rations served exceeds the hospital subsistence allowance, the Chief, Food Service Division, may desire to use columns f and g as the basis for entry of food issues in order to de-

tect operational errors and losses, to improve security, as well as to provide daily control over food issues.

★*c. Storage.* All food items not required for immediate use will be stored in secure central food supply storerooms. Where appropriate, central refrigerated storerooms will be provided.

★*d. Internal food requisitions.* Issue of subsistence items from the hospital food supply storerooms will be made on presentation of DA Form 2930 (Hospital Food Service—Kitchen Requisition) with columns a through c completed, signed by the requisitioning representative, and countersigned by the dietitian or other authorized person. Hospitals utilizing the AMEDD ADP system for hospital food service may use the INGREDIENT SUMMARY printout, properly dated and signed, in lieu of DA Form 2930.

★*e. Food issue to kitchens.* Food supplies requisitioned on DA Form 2930 (or INGREDIENT SUMMARY printout) will be assembled for delivery by subsistence section personnel in the quantities and at the time requested by the kitchen ingredient room. Quantities actually issued will be entered in column d. DA Form 2930 (or INGREDIENT SUMMARY printout) will then be signed by the individual authorized to issue subsistence items and forwarded with the supplies to the receiving kitchen. After verification of the receipt of all supplies and checking column e, DA Form 2930 (or INGREDIENT SUMMARY printout) will be signed by the authorized kitchen representative. If the cost of rations served exceeds the hospital subsistence allowance, the chief, food service division, may use columns f and g of DA Form 2930 as a daily control over food issues.

f. Inventory control. All subsistence items on hand in the central food storerooms will be inventoried on the last day of the month on DD Form 160 (Inventory of Class (#) Quartermaster Supplies) by an individual designated by the commander of chief, food service division.

9–13. Food cost management. The chief, food service division, is responsible for establishment and maintenance of proper security measures and adequate controls over food supplies. Primary emphasis will be placed on food inventories, food purchases, kitchen requisitions, and food issued. Documents and records pertaining to food purchased, stored, and issued will be maintained by the chief, food service division.

a. DA Form 1836 (Daily Record of Hospital Food Service Operations) will be maintained on a calendar month basis for the management and control of food costs.

(1) *Value of food receipts.*

(*a*) The daily total value of foods received by the food service division, as recorded on the priced and extended DA Form 3161 (Request for Issue or Turn-in), will be recorded for each day on which foods are received with a FY cumulative total.

(*b*) When food products are delivered directly by the vendor to the MTF for which billing is accomplished at the end of the accounting period, the cost of the item delivered each day will be included in the value of food receipts for that day.

★(2) *Rations earned.* The daily patient rations earned will be calculated by totaling columns ff and gg from DA Form 1833. The nonpatient rations served will be calculated by totaling columns cc, dd and ee from DA Form 1833. The daily patient rations earned and the daily nonpatient rations served and the respective FY cumulative totals will be recorded daily.

★(3) *Authorized monetary value allowed for subsistence.* The daily allowances for patient and nonpatient rations will be calculated as follows:

(*a*) Multiply the value of the basic daily food allowances for one person, as computed for hospitals (BDFA x 2%) by the TISA or the commissary, by 1.08; and multiply the result by the total number of patient rations.

(*b*) Multiply the basic daily food allowance for hospitals provided by the TISA by the number of staff and guest rations.

(*c*) The sum of the amounts obtained under (*a*) and (*b*) above, will constitute the total daily hospital subsistence allowance. Daily totals and cumulative totals of the authorized monetary value will be maintained.

(*d*) For Thanksgiving and Christmas when an increased allowance is authorized, the basic daily food allowance for hospitals as provided by the TISA is increased by 1.25 prior to making the above computations.

(*e*) Hospitals which have been granted a higher hospital subsistence allowance (see para 9-13*d*(4)) will be notified separately as to the method of computation of the hospital subsistence allowance.

(*f*) With the exception of Walter Reed Army Medical Center and Fitzsimons Army Medical

Center, the value of the basic daily food allowance will be computed by the troop issue subsistence officer (TISO) at each CONUS installation and the agency or agencies designated by the major oversea commanders, as appropriate, in accordance with AR 30-18, and will be furnished the commander of the Army medical treatment facility prior to the beginning of each accounting period. At Walter Reed Medical Center and Fitzsimons Army Medical Center, this service will be provided by the installation commissary officer.

(4) Entries on DA Form 1836 will be as follows:

(*a*) *Column b.* Enter the daily net value of food received from the period voucher(s), requisition(s), or other documents for each day on which food items were received.

(*b*) *Column c.* Enter the cumulative net value of food received or menu items purchased for the fiscal year to date.

(*c*) *Column d.* Enter the daily monetary allowance for subsistence for patients computed by multiplying the number of patient rations earned for the day shown in column j by the authorized patient ration rate shown on line 36.

(*d*) *Column e.* Enter cumulative monetary allowance for subsistence for patients for the fiscal year to date.

(*e*) *Column f.* Enter the daily monetary allowance for subsistence for nonpatients computed by multiplying the numbers of nonpatient rations earned for the day shown in column 1 by the authorized nonpatient ration rate shown on line 37.

(*f*) *Column g.* Enter the cumulative monetary allowances for subsistence for nonpatients for the fiscal year to date.

(*g*) *Column h.* Enter the sum total of column d and f.

(*h*) *Column i.* Enter the sum total of column e and g.

(*i*) *Line 36.* Enter the authorized rate for the month for patients.

(*j*) *Line 37.* Enter the authorized basic daily food allowance for the month for nonpatients.

(*k*) *Line 38.* Enter the actual hospital subsistence allowance for the month computed by dividing line 35 column b by line 35 column n.

(*l*) *Line 39.* Enter the authorized hospital subsistence allowance for the fiscal year to date computed by dividing line 33 column i by line 33 column o.

(*m*) *Line 40.* Enter the actual hospital subsistence allowance for the fiscal year to date computed by dividing line 33 column c by line 33 column o.

b. Determination of food costs.

(1) A daily comparison of the FY cumulative authorized monetary value allowed for food and cumulative value of food receipts will indicate the extent to which the cost of actual food receipts are exceeding or are less than the monetary value of food authorized by the hospital subsistence allowance for the fiscal year to date.

(2) An end of the month comparison of the authorized hospital subsistence allowance and the actual expenditures made for food for both patients and nonpatients is an index food costs for that particular month.

c. Verification of monetary value for food receipts. The total value of food receipts for the month recorded on DA Form 1836 will be verified as of the end calendar month with the finance and accounting officer's records and adjusted if necessary. At the end of each calendar month the cumulative value of food receipts (column c, DA Form 1836) will agree with the costs accrued in food procurement as recorded in the cost ledger. (Applicable only to facilities financed from BP 840000.)

d. Food cost control.

(1) Computing the cost of the ration served on the basis of delivered food purchases may result in a requisitioning cycle cost that exceeds the local monetary value per ration for a particular month, but yet will not exceed the authorized hospital subsistence allowance developed locally for the fiscal year.

(2) The monthly authorized hospital subsistence allowance may be exceeded due to increases in inventory caused by the timely purchase of food items to effect a monetary savings during a subsequent period, the quantity purchase of food items that will be consumed over an extended period, or due to an established requisition cycle in which the purchase date occurs just prior to the end of the month with the quantity of supplies purchased to be consumed during and subsequent to the following month.

(3) Each month the actual expenditure for rations must be compared to the authorized monetary value allowed for subsistence and a determination made as to the cause for any excess cost deviations so that proper action can be taken to assure that the authorized hospital subsistence allowance for the fiscal year will not be exceeded.

(4) When the authorized hospital subsistence allowance is insufficient to provide adequate subsistence, commanders may request authority from HQDA(DASG-RMP), WASH, DC 20310 to utilize a higher rate. Normally, requests will be submitted only when less than 100 rations per day are being served. Requests will include the following:

(*a*) Average number of rations served per day for each of the 3 preceding calendar months and the authorized hospital subsistence allowance for each of the 3 months.

(*b*) Forecast of the average number of rations to be served per day for the current and each of the succeeding 3 months and the hospital subsistence allowance for the current month.

(*c*) Statement of the conditions necessitating an increased allowance.

(*d*) Recommendation as to amount of increased allowance needed, expressed as a percentage (e.g., a 10 percent increase) over the hospital allowances as authorized by paragraph 9-13*a*(3).

(*e*) Ability of the command to finance the increased allowance.

(*f*) The feasibility of providing subsistence by means other than hospital food service (para 9-2*b*).

(*g*) A statement indicating that costs will not be increased as a result of providing items or services to nonpatient personnel when such items or services are not provided in installation troop feeding facilities. (It is intended that nonpatient personnel subsisting in hospital food services be provided subsistence at a comparable level with troop feeding facilities.)

e. Review of DA Form 2930. After issue and receipt of food in the kitchen, DA Form 2930 will be reviewed and retained by the chief, food service division to insure accuracy of daily food issue documents and spot check of critical food items.

9–14. Clinical dietetics management. The dietetic treatment of patients in medical treatment facilities will provide individualized dietary regimens to enhance patients recovery, to provide optimum nutrition, and to insure consumption of food required. The dietitian, dietetic technician, and diet aide (or dietetic assistant), will perform the professional and supportive personnel duties required to assure that the proper diet is planned and served to the patient.

a. Ward rounds with medical officers. To provide specialized dietary regimens as prescribed by the medical officer, knowledge of the medical treatment of the patient will be acquired through participation in ward rounds, patient care conferences, professional meetings, and review of the patient's records.

b. Liaison with nursing service personnel. Meal by meal contact will be maintained with nursing service personnel to assure the accuracy of diet orders and to assist nursing service personnel with problems that may arise in the dietetic treatment of the patient.

c. Diet orders. DA Form 1829 (Hospital Food Service—Ward Diet Roster) is the basis for transmitting the physician's orders for dietary regimens for patients. The nurse in charge of each ward will furnish accurate diet information for each meal as prescribed by the physician for each individual patient.

d. Patients interviews. Interviews to obtain food preferences and to inform patients of dietary restriction on prescribed diets will insure a high standard of dietetic service. DA Form 2924 (Hospital Food Service—Dietary History Record) will be maintained for each patient on a modified diet, giving dietary history, food likes and dislikes, diet orders, and other pertinent dietetic information.

e. Dietetic progress notes. Patients seen in the Nutrition Clinic for dietary counseling will have resulting entries or summaries recorded on SF 600 (Health Record—Chronological Record of Medical Care) in the Outpatient Treatment Record or Health Record. Nutritional care/dietary counseling for the inpatient will be recorded on SF 509 (Health Record—Doctor's Progress Notes). When the entry is complex and lengthy, the SF 513 (Medical Record—Consultation Sheet) will be used with a referral note on the SF 600 or SF 509, whichever is applicable. Each entry will be identified as an entry made by a qualified dietitian or an authorized designee, dated, and signed.

f. Dietary counseling. Inpatient dietary counseling will be provided, as required, and will be continued during the patient interviews. Upon request of a physician, nurse practitioner, or nurse specialist, outpatient dietary counseling will be scheduled in groups or on an individual basis in the nutrition clinic.

g. DA Form 2900 (Selective Menu). Selective menus with choices of food and size of portion checked by bed patients on regular diets will provide the types of foods most acceptable to the pa-

tient and serve to reduce food waste. Selective menus for modified diets may also be used for patient satisfaction and teaching purposes where locally feasible. DA Form 2900 may be modified to change the diet name.

h. Diet menu plans (DA Forms 2901 series through 2908 series, and 2909). A diet menu plan prepared for each type of diet established in the standard hospital diets will assure more accurate service of food to patients on modified diets. Each type of food required for the diet menu may be identified by a descriptive nomenclature or code. Substitution of food items on diets and indication of size of portions to satisfy the likes and dislikes of the patient may be made each day on the appropriate daily menu plan.

i. Daily listings of food required. All types of food preplanned on DA Forms 1824 and 1824-1 (Hospital Food Service—Master Menu—Part I, and Parts II and III) will be consolidated on DA Forms 2932, 2932-1, and 2932-2 (Food Code Worksheet Part I—Breakfast; Part II—Dinner and Supper, Hot Foods; Part III—Dinner and Supper, Cold Foods). This daily listing of foods is a basis for advance and daily food orders, food production, and service of diets to patients.

j. DA Form 2925 (Hospital Food Service Modified Diet Record). Entries on this form, listing the number of diets served by category, will be made daily. This record is maintained on a monthly basis to provide data for planning for personnel, food, and forms.

k. DA Form 1831 (Tray Identification). This form will be prepared for each patient served on the wards. The form and the patient's menu will be checked each meal.

l. Patient tray service. Procedures pertaining to the distribution and service of food to patients eating on the wards will be coordinated with the chiefs of service concerned with patient care. Tray service will be limited to patient feeding. Duty personnel are prohibited from eating on the wards or in the ward kitchens. Tray service to patients will be scheduled to avoid excessively early breakfast and supper meals.

(1) *Isolation service.* Personnel assigned to food service duties in contagious areas will be thoroughly instructed in isolation techniques. Food glasses, dishes, silver, and supplies which have been in direct contact with patients on isolation will not be returned to the central kitchen or central trash area. Dishes, glasses, and silver will be cleaned and disinfected on the isolation ward. If such facilities are not available on the ward, or the isolation is carried out on a nonisolation ward, disposable items will be used. Any nondisposable items used will be retained in the patient's unit until he is removed from isolation and will be washed in the patient's room after each meal. At the termination of the isolation, the nondisposable items will be washed in hot, soapy water, rinsed, and sanitized in a Wescodyne solution of 50 ppm available iodine (3 oz. Wescodyne to 5 gal. water) for 10 minutes, and then returned to the central kitchen area to be processed through the dishwasher.

★(2) *Centralized tray service.* Where the complete tray is assembled in the main kitchen, and transferred to the ward in mobile hot and cold carts, or an insulated tray system, the following will apply:

(*a*) Tray service to patients will be scheduled at times best suited to the patients and routines of each particular ward.

(*b*) Patients scheduled for early, late, and delayed trays will be served with accuracy and promptness as listed on DA Form 2926 (Hospital Food Service—Early, Late or Delayed Tray Roster).

(*c*) DA Form 2927 (Hospital Food Service Telephone Diet Order) will be maintained in the clinical dietetics section and in the kitchen to insure accurate transmission of diet and tray information.

(*d*) An accurate DA Form 2928 (Hospital Food Service Nourishment and Forced Fluid Roster) will be maintained to serve as a guide for preparation and delivery of nourishments and to insure that the patient receives the appropriate nourishment for the diet ordered.

(*e*) DA Form 2929 (A Hospital Food Service Cart Loading Guide) will be used to ensure that proper amounts of bulk foods and required utensils are accurately loaded on each cart for delivery to the wards.

m. Nutrition education. Nutrition education will be provided in support of environmental health (preventive medicine) programs.

n. Dietetic consultation. Dietetic consultations as distinguished from nutritional care/dietary counseling will be provided to the medical staff by entry on SF 513 (Medical Record—Consultation Sheet) in the patient's medical record.

9–15. Food production and service management. Control measures will be established to as-

sure high quality production of all prepared food items with a minimum of waste.

a. Cook's worksheets. DA Form 1826 (Hospital Food Service Cook's Worksheet, Part I—Breakfast), DA Form 1826-1 (Hospital Food Service Cook's Worksheet, Part II—Dinner and Supper, Hot Foods), and DA Form 1826-2 (Hospital Food Service Cook's Worksheet, Part III—Dinner and Supper, Cold Foods) will be prepared daily for both regular and modified diet foods as a food production control. The food items for each meal will be entered on DA Form 2932, DA Form 2932-1, and DA Form 2932-2, which are then attached to the appropriate cook's worksheet form. The type and amounts of food listed for each meal are the basis for preparation of DA Form 2931 (Hospital Food Service—Food Preparation Worksheet—Night Supper, Pastry, and Vegetable). Outputs from the AMEDD ADP system for hospital food service may be used in lieu of the DA forms above, where available.

b. Standardized recipes and portion control. Standardization of recipes and portion control provide uniformity of product and cost control. DA Form 1827 (Recipe Card) will be maintained for standardized recipes used in food preparation. Recipes from the AMEDD ADP system for hospital food service may be used where available.

c. Food preparation.

(1) Modified and regular diet food preparation will be consolidated to the maximum extent practicable to improve quality of food prepared and to minimize the high food and labor costs inherent in specialized preparation.

(2) Modified diet food, supplemental feedings, forced fluids, and tube feedings will be prepared with accuracy and with special attention to quality.

d. Patient tray service. Food preparation methods will be studied and improved to provide quality food for patient tray service. Food preparation methods for centralized tray service will be adjusted to assure foods that will remain palatable and attractive on the hot plate during the holding period on the cart.

e. Portion control. Portion control will be exercised by use of standardized recipes and standard serving utensils.

f. Food waste. Causes of food waste and leftovers will be analyzed and adequate conservation measures established.

g. Meat processing. Meat will be processed according to locally predetermined specifications and issued in amounts requisitioned. DA Form 1834 Meat Processing Record) will be maintained. A DA Form 1835 (Hospital Food Service, Food Receipt and Consumption Record) may be used to facilitate handling, inventory, and economical utilization of stock. Where carcass meats are used, individual cuts will be identified again following carcass breakdown.

h. Meal service. Meal hours will be scheduled to provide service for patients at normal eating times. Excessively early breakfast and supper for ward and dining hall patients will be avoided. Ambulatory modified diet patients, ambulatory orthopedic patients, and female patients will be served in the dining rooms to the maximum extent possible. Duty personnel will be scheduled at times which do not interfere with patients' service. To maintain high quality food, the meal hour span will be reduced to the minimum. Midnight supper will be prepared and served to night-duty personnel and patients admitted after the scheduled supper hour.

9–16. Holiday menus. Payment for printing holiday menus for use at Army hospitals at Thanksgiving and Christmas is an authorized expenditure from locally available appropriated funds. The use of multicolors for these menus is considered to have functional value within the meaning of paragraph 1-15, AR 310-1. If procured commercially, the printing of these menus will be reported on JCP Form 2 (Quarterly Commercial Printing Report) required by paragraph 4-19, AR 310-1. Including the cover, a menu will not contain more than four printed pages, nor will it exceed in size 7 by 9 inches. The use of photographs of individuals is not authorized.

9–17. Termination of hospital food service operations. *a.* During the inactivation period of a MTF, reduction in food inventory stocks and food procurement will be phased commensurate with diminishing feeding requirements. The food inventory will be reviewed to determine the presence of surplus items. Excesses, where indicated, will be turned into the installation commissary for reimbursement to Army Medical Activities funds. To the extent practicable, economical utilization of subsistence stores on hand will take precedence over additional food procurement. The ideal objective is to reduce the food inventory to absolute minimum quantities needed for current food service operations so as to avoid, if at all practicable, transfer to other MTF of food items of the type not returnable

to the commissary for reimbursement to Army Medical Activities funds.

b. When food service operation terminates, special patient feeding items which are not returnable to the commissary for reimbursement will be transferred to another Army MTF (usually the nearest facility) as directed by the surgeon of the major command concerned. Transfer will be in accordance with AR 710-2. Food items description, unit, quantity, unit (cost) price, and total value will be listed on the transfer document. Sufficient copies will be prepared to provide for the following distribution:

(1) Two advance copies for mailing direct to the receiving Army MTF marked for the attention of the hospital food service.

(2) One copy to accompany shipment.

★**9-18. Dining hall cashier.** *a.* The chief, food service division will be responsible for:

(1) Insuring that the dining hall cashier will be:

(*a*) Stationed at each diner's entrance to the dining hall.

(*b*) Supplied with prenumbered DA Forms 3351, (Signature Headcount Sheet) DA Forms 3801 (Guest Log for Meals), and DA Forms 3158 (Statement of MSA Dining Hall Cash Receipts and Meals Served).

(*c*) Substituted for by a responsible individual whenever meals are to be served during the absence of the regularly scheduled dining hall cashier.

(2) Providing standard operating procedures that outline the cashier's duties and responsibilities, to include current charges for meals according to category as prescribed in AR 40-330.

(3) Insuring procedures are established for the proper safeguarding of the change fund and monies collected by dining hall cashiers until these funds are turned over to the medical services accountable officer (MSAO) or his/her representative.

b. Duties of dining hall cashiers are as follows:

(1) A meal attendance headcount will be taken by the dining hall cashier for each meal served. For headcount accounting purposes, regardless of the amount of food consumed or meal rate collected, each person who signs for a meal will be counted as one meal consumed.

(2) Make certain that each diner has in his/her possession the hospital's required dining facility identification to insure that only authorized personnel are allowed to enter the dining hall. Personnel not meeting this requirement will be referred to a predetermined office to obtain the necessary authorization.

(3) Require each individual authorized to dine at government expense to legibly sign name, rank and unit on DA Form 3351. Food service personnel, kitchen police, and other authorized personnel eating early or late meals will be included.

(4) Require each officer and enlisted person entitled to basic allowance in lieu of subsistence to sign name, rank, and unit on DA Form 3801 and to pay cash at the prescribed rate for the meal concerned. Also, require civilian food handlers and personnel not entitled to rations at Government expense to sign DA Form 3801 and pay cash for the meal consumed.

(5) Require individuals who are issued a box lunch to sign the appropriate form to include payment, when indicated.

(6) At the completion of each meal served, the dining hall cashier will compute the number of meals consumed by adding the number of signatures appearing in DA Form(s) 3801 and DA Form(s) 3351. The number of meals consumed will then be entered on the applicable column of DA Form 3158. At the close of the scheduled meal serving period, the dining hall cashier will line out all unused sections of DA Form 3351 and DA Form 3801. The cashier will also insure that total cash collections equal the total shown on the completed portions of DA Form 3801. Accountability and collections for the midnight service may be recorded on the DA Form 3801.

(7) The dining hall cashier will turn in cash collections and forms daily to the MSAO cashier who will give a receipt in the amount of the cash turn-in to the dining hall cashier. Cash collections received on weekends and holidays will be turned in to the MSAO at the beginning of the next regularly scheduled work day. Procedures will be scheduled to insure that proper accountability and safekeeping of funds are maintained for collections received during non-regularly scheduled workdays.

c. MTFs are authorized to use a multiple key cash register in the hospital dining facility for cash collections and headcount statistics in lieu of other required cash collection procedures. Facilities using a cash register will submit to the MACOM a copy of the local procedures governing the operation. These procedures will include, as a minimum, the internal controls mentioned below.

(1) The cash register will be a model and type

having sufficient identification keys and related counters for each paying and non-paying personnel category served by the dining hall.

(2) The register will visibly indicate the amount collected.

(3) The register will have the capability of providing an individual receipt as well as a detailed transaction tape which can only be cleared with a key.

(4) A cash register receipt indicating amount paid and the date of payment will be given to each payer.

(5) The total clearing key will not be in the possession of the dining hall cashier. The dining hall cashier *will not,* under any circumstances. "clear" the cash register.

(6) The dining facility cashier who operates the cash register will at the end of each meal turn in all cash in the cash register to the individual responsible for clearing the cash register along with his/her portion of the completed DA Form 3158.

CHAPTER 10

MEDICAL LIBRARIES

10–1. Purpose and scope. This chapter prescribes policies and procedures for the operation of medical libraries at Army MTF. Major overseas commanders will adopt, with respect to Army MTF, such portions as are applicable and may establish appropriate procedures and controls in connection therewith. This regulation is not applicable to libraries operated under the monitorship of The Adjutant General.

10–2. Definitions. For the purpose of this regulation, the following definitions apply:

a. Medical library. An integral part of an Army MTF established for the purpose of providing professional books and periodicals for reference, education, and research.

b. Medical librarian. The term "medical librarian" refers to the military or civilian member of the staff whose work requires the application of professional library techniques in medical library administration, supervision, organization, and operation.

c. Professional books and periodicals. Professional books and periodicals include all library material required for use by MTF personnel in direct or indirect patient care. This includes both the professional and administrative staff, officer and enlisted.

10–3. General policies. *a. Establishment.* Medical libraries will be established at all medical centers and hospitals subject to the approval of the major commander concerned. (At clinics, a desk and officer reference collection of medical books and periodicals will be maintained.).

b. Separate property accounts. Medical libraries will maintain separate library accounts under the provisions of AR 735–17. Each medical library account will be assigned a Department of Defense Activity Address Code (DODAAC) to be used as an account number under provisions of AR 735–5. Major medical commands or command surgeons will obtain and control DODAAC as prescribed in AR 725–50 and DOD 4000–25–D, DOD Activity Address Directory.

10–4. Personnel. *a. General.* The number of medical librarians provided to staff the medical library will be in relation to the type and amount of administrative and operational duties, to include reference work, resulting from the size of the medical and allied staff, and the teaching and research programs of the MTF. Assistant medical librarians may be employed when the need therefor exists, subject to the approval of the major commander concerned, as applicable.

b. Selection and assignment. The selection and assignment of civilian medical librarians, when the utilization of such personnel is authorized within the limits of this section, are functions of the local command and will be accomplished in accordance with the applicable Civil Service rules and regulations.

c. Bonding requirements. Civilian medical librarians are covered by the position schedule bond under the position title "Property Officer."

d. Duties. Medical librarians will perform the following duties or so much of them as are appropriate considering local requirements:

(1) *Medical reference.* Make available to the medical and allied staff reference material concerning the most recent as well as historical developments in medicine, surgery, and other specialties represented in the clinical coverage in the medical and allied fields. The compilation of reference lists and bibliographies is an inte-

gral part of the reference function of the medical library. Related reference work consists of interlibrary loan service, assistance in the preparation of professional papers, and assistance to medical journal clubs organized to facilitate the interchange of information on Army medical trends. Medical references include the use of secondary sources such as Index Catalogs to The Surgeon General's Library, Current List of Medical Literature, Quarterly Cumulative Index Medicus, abstract journals, and special bibliographies.

(2) *Journal and book selection.* Subject to review and final selection by the Medical Library Committee, recommend books and journals to be purchased, discarded, replaced, or rebound. Recommendations for additions to the library are to be based upon scope of the subject as related to the needs of the medical program and the present book stock and periodical subscription. Recommendations for retention or removal of material are based on its use, indications of future needs and requests, condition of material, and budgetary limitations.

(3) *Training medical and allied staff in use of library.* Conduct a continuous program of orientation lectures and instructions for the purpose of training the medical and allied staff in the use of medical reference tools and inform users of the types of reference and other services available.

(4) *Cataloging of materials.* Catalog, classify, and arrange medical library collections in such a manner as to ensure their ready access.

(5) *Referring literature to appropriate individuals.* Make a continuing examination and analysis of all journals, books, pamphlets, and other materials upon their receipt in the library to determine possible application to all studies and research programs, either planned or presently conducted by the staff, and to bring pertinent material to the attention of the individual concerned.

(6) *Promoting use of medical library and facilitating interlibrary loan of material.* Develop effective public relations within the MTF in order to promote the use of the medical library resources and to attain maximum use of medical literature. Also, maintain professional relationships with other library staffs, clinics, and local medical societies to ensure full cooperation in the interchange of information and interlibrary loan materials.

(7) *Accounting records.* Maintain accountability records as outlined in AR 735–17.

10–5. Medical library collections. *a. Classifications.* Classification of books and periodicals will be determined locally in accordance with accepted library practices.

b. Acquisition. In selecting books and periodicals for acquisition, the following principles will be adhered to:

(1) Books will be selected in response to the needs of the staff of the MTF. With but few exceptions, books and monographs should have been published within the last 10 years. Representatives of all staff activities will be consulted concerning medical book procurement.

(2) Current medical periodicals and publishers' catalogs and announcements will be reviewed regularly for listings or new books. A file of current publishers' catalogs will be maintained.

(3) The following materials should be used in the selection of medical books, periodicals, and journals:

"MEDICAL BOOKS IN PRINT"—A complete list of the medical books issued by all medical publishers in America, including the known forthcoming books in each field. SOURCE: Major book dealers or publishers.

"TRADE PRICE LIST"—A listing of popular periodicals of every field. SOURCE: Major subscription dealers.

c. Periodicals. Each library will subscribe to a selection of periodicals covering the various specialties in the MTF program. The list will be reviewed each year to eliminate those periodicals not used after due consideration of the mission of the facility and the probability of future requirement for this subject matter. The principles pertaining to book selection are also applicable to periodical selection. These principles should be supplemented by giving consideration to the procurement of abstract periodicals in order to provide for a broader

coverage of the field of periodical literature than would be possible by the procurement of individual titles under a limited budget.

10–6. Procurement. *a. Funding.* Books and periodicals for medical libraries will be purchased from funds made available to operate the facility obtaining the items.

b. Medical book sets and periodicals. The procurement and issue of medical book sets and periodicals, together with the withdrawal of volumes from such book sets and augmentation thereto, will be determined by The Surgeon General's Board for Review of Medical Professional Books and Periodicals based upon the recommendation of the major command surgeons.

c. Books. Professional books will be purchased in accordance with AR 710-2 and AR 40–61.

d. Periodicals.

(1) Periodicals required will be procured locally by MTF through subscriptions placed direct with publishers or dealers.

(2) Payment therefor will be made from current appropriations available at the time the subscriptions are placed.

(3) Where it is advantageous for the purpose of economy to subscribe to periodicals for more than 1 year, Army medical activities may place such subscriptions direct with publishers or dealers.

10–7. Records of accountability. Books received in the medical library or clinic will be accounted for in accordance with AR 735–17. Desk and office reference collections will be accounted for on appropriate property book. Separate DA Forms 3328 (Organization (Installation) Property Record) will not be established for each book. The maximum number of books will be entered on the back of one DA Form 3328.

10–8. Administration. The following procedures are applicable to medical libraries established at those MTF referred to in paragraph 10–3*a*.

a. Medical library committee. A medical library committee will be established to serve as liaison between the medical library and the medical and allied staff. This committee will be composed of at least three members and will include the medical librarian. The membership of the committee will represent a cross section of the professional elements of the MTF. The functions of the committee will be to approve acquisition of new medical books and periodicals recommended for procurement, the establishment of local rules and regulations governing the use of the medical library, and the determination of periodicals to be bound and materials to be discarded.

b. Circulation. The medical librarian will establish a method for circulating books and periodicals to meet the needs of the MTF. The method established will ensure the return of materials to the medical library and provide circulation records, the analysis of which will serve as a guide to those subject fields which are in demand at the MTF. In general, one copy of each book will be retained in the library for reference purposes. Certain books of highly specialized interest may be issued to an office or individual when the interest is total. In limited cases when an officer, by virtues of his duties requires a book for continual reference, duplicate copies should be provided.

c. Interlibrary services. The medical librarian will be responsible for obtaining loan, photoduplication, and general reference services which are required by the medical and allied staff in connection with their official duties. Such services will be obtained from local military or civilian sources, or from the National Library of Medicine, 8600 Rockville Pike, Bethesda, MD 20014. Information about services provided by the National Library of Medicine and the rules under which these services are available are contained in a National Library of Medicine pamphlet entitled "Services," which is referred to as Public Health Publication No. 1533. Copies of this pamphlet may be requested direct from the Director of the National Library of Medicine.

(1) Postage costs incurred, relating to the interlibrary loans of medical books, periodicals and other materials, are properly chargeable to funds made available to installations provided such loans are used for reference, education, or research in connection with medical care.

(2) In those rare instances where interlibrary loans are made for the exclusive and personal use of individuals, postage costs incurred in the mailing of the items listed in (1) above will be assumed by the borrower.

d. Disposition of books and periodicals.

(1) *Books.* For libraries, the medical librarian will determine, with the concurrence of the Medical Library Committee, the books that are obsolete, unserviceable, or excess to the needs of the library; for a desk and office reference collection, the officer in charge of the clinic will determine the books that are obsolete, unserviceable, or excess to the needs of the clinic. These books will be disposed of in accordance with AR 735–17. Transfer of excess books to Federal agencies is authorized under DOD 4160.21–M.

(2) *Periodicals.* All medical and scientific periodicals, regardless of language or date, which are excess to the needs of the MTF will be declared surplus and processed under the provisions of AR 775–1 or as in (3) below.

(3) *Exchange.* Under the authority contained in AR 735–17, The Surgeon General has determined that exchange of excess professional and technical books and periodicals in Army medical libraries can effectively be accomplished through membership in and use of the services of book exchanges, such as Universal Serials and Book Exchange, Inc., 3335 V Street NE., WASH, DC, 20018, and the Medical Library Association Exchange, 919 North Michigan Avenue, Chicago, IL 60611. For purpose of exchanging such books and periodicals, MTF are authorized to join and utilize these exchanges. Membership fees, shipping charges, and handling fees incurred as a result of this activity will be financed from funds available to operate the MTF. AR 55–16 and AR 340–3 govern when shipping books and periodicals from MTF to the book exchange.

e. DA Pam 28–30 (Library Operational Guide) contains operational guidance for medical libraries.

CHAPTER 11

FEDERAL AVIATION AGENCY (FAA) MEDICAL EXAMINATIONS AND CERTIFICATES

11–1. General. *a.* This chapter establishes procedures by which personnel listed in *b* below may be given a medical examination for and issued Federal Aviation Agency Medical Certificates, Second Class and Third Class.

b. The following personnel only may be given FAA medical examinations:

(1) Commissioned officers and warrant officers on active duty with the Army who are designated Army aviators.

(2) Army personnel who are performing or may perform military air traffic control duties and who desire FAA certification or for whom such certification is desired.

(3) Designated Army aviators of the Army National Guard and designated Army aviators in the Army Reserbe Aviation officer training program.

(4) Civilian flight instructors and test pilots employed by the Department of the Army.

(5) Nonrated Army personnel who currently hold valid second or third class FAA medical certificates or who desire to obtain such certificates.

(6) Other personnel eligible under Department of Defense or Department of the Army medical programs.

11–2. Designated medical facilities. The FAA has authorized the senior flight surgeon or aviation medical officer of each of the activities listed in part III, Federal Aviation Agency Directory of Aviation Medical Examiners to exercise the authority of a Federal aviation medical examiner. This directory is available at the nearest FAA facilities. The incumbent officer in each position listed is automatically so authorized, as is his successor, whenever personnel changes are made. It is emphasized that no individual flight surgeon or aviation medical officer shall exercise authority of a Federal aviation medical examiner unless he is assigned to a designated Army MTF and is the senior flight surgeon or aviation medical officer at the facility. Medical commanders desiring that their facility be designated as an approved facility to conduct second and third class FAA medical examinations should submit requests through normal channels to HQDA (DASG-HCH), WASH DC 20310.

11–3. Examinations. MTF designated will conduct medical examinations for personnel coming within the scope of this section, subject to availability of time, personnel, and facilities as determined by the commander.

11–4. Authority to issue certificates. By agreement with the FAA, authority to issue class II or class III medical certificates is delegated to the senior flight surgeon or aviation medical officer assigned to the MTF designated. Upon successful qualification, candidates will be issued class II or class III FAA medical certificates in accordance with the provisions of the FAA Guide for Aviation Medical Examiners.

11–5. Disposition of examination reports. Upon completion of examination, whether or not the candidate is qualified, the completed examination form (FAA–8500–8) will be mailed directly to the FAA, using the return self-addressed envelopes which are supplied for this purpose.

11–6. Supply of FAA publications. *a.* The Guide for Aviation Medical Examiners, Examination Form (FAA–8500–8) and return enve-

lopes will be distributed by the FAA direct to facilities concerned.

b. Requests for resupply of these items will be addressed to the FAA by the authorized designee, using the Requisition for Medical Forms (FAA–473) which will be issued in the initial distribution of forms.

★CHAPTER 12

ARMY BLOOD PROGRAMS

12–1. General. This chapter implements Department of Defense Directive 6480.5 entitled Military Blood Programs. It addresses the command blood programs and the medical blood programs, and their relationships with the Military Blood Program and other uniformed services' blood programs, civilian blood programs, National Blood Policy, and the National Emergency Blood Program. Senior commanders of major Army forces stationed outside of the United States may adopt such portions of this chapter as are applicable and in consonance with the programs and plans of the appropriate Unified and/or Specified Commands, and may establish desired procedures and controls in connection therewith.

12–2. Command blood programs. The Army is charged with the responsibility of providing from its own resources the blood and blood component requirements for all patients receiving care in its military medical treatment facilities without adverse impact on blood programs of civilian communities, and is restricted in peacetime to blood collections on military installations from military personnel, their dependents, and civilian Federal employees. (The restrictions may be modified during periods of national emergency, mobilization, or war by the Federal Emergency Management Agency, executive of the National Emergency Blood Program, as described in the Code of Federal Regulations, Sec. 32A, Part 107.) Specific responsibilities are assigned as follows:

a. Every commander is responsible for providing volunteer donors at the frequency and in sufficient quantity to enable Army medical treatment facilities to maintain a working inventory of blood in the appropriate groups and types for usual treatment needs, and additionally for contingency and emergency needs. Some interruption to working and training schedules will be inevitable, as donors should normally be made available during regular working hours; however, close coordination between the unit commander, the installation's blood donor coordinating representative, and the provider of the blood service collection team can minimize the time lost in making donors available.

b. Installation commanders will formally establish and operate an installation blood program at installation staff level to coordinate the provision of volunteer donors from their own unit, subordinate units, and tenant units with the military blood service collection teams. Additionally, commanders will provide maximum effort to meet critical blood quotas assigned to medical command blood donor centers during contingencies and/or mobilization periods.

c. Commander, USA Health Services Command, and oversea medical commands will provide the requisite blood donor collection services from Army Medical Department resources, or will arrange for these services from other approved sources.

d. All commanders will develop and maintain a program of donor motivation and education. When operational necessity permits, the award of a 3-day pass for "Exceptional Performance of Duty" to military personnel who donate blood is encouraged, as is a grant of up to 4 hours of excused absence in conjunction with an actual donation of blood by civilian employees. Other incentive and recognition programs should be developed. Additionally, all eligible members of the military community should be encouraged to donate. Student groups in their entirety shall be made available for voluntary blood donation.

e. Donors will not be provided in support of civilian blood programs and civilian communities without written authority of the Commander, USA Health Services Command. This constraint will insure that such a diversion of resources will not impact adversely upon the Army's capability to provide for its own needs.

f. All blood and blood components provided by the command blood programs (with the exception of that provided in para 12-2*e*) will become the property of the medical blood programs.

g. Donor nourishments are to be provided to assist in preventing minor donor reactions and as a gratuity to the donors. These nourishments should be provided in the general area of the donation site, and normally consist of beverages (fruit juices, iced tea, coffee) and pastries or cookies. Provision of

these nourishments is an authorized Army expense from local funds, and is usually provided by the local commander if the blood collections are not accomplished in MEDDAC/MEDCEN facilities. Nourishments in connection with blood collections accomplished by the American National Red Cross or other civilian organizations will be furnished by those organizations.

h. All donations under the auspices of the command blood programs will be voluntary in compliance with the National Blood Policy as published in the Federal Register, Volume 39, Number 176, pages 32702-32703, September 10, 1974, and sequelae.

i. A records system will be developed and maintained to provide the data necessary for measuring the achievements of the command blood programs and for evaluating the quantity and quality of the provided medical technical services.

12-3. Medical blood programs. Policy guidance and general technical supervision of the provision of medical technical services in support of the Army command blood programs and the entirety of the Army medical blood programs are the responsibility of The Surgeon General. Commander, USA Health Services Command, is designated and charged with all operational aspects of providing the necessary blood donor centers and medical technical services in support of the command blood programs and with operating the medical blood programs within that assigned geographic area. Senior commanders of Army forces in all other geographic areas are similarly designated and charged for their respective areas.

a. The Surgeon General is the holder of the Department of the Army establishment and product licenses as specified in the Memorandum of Agreement between the Food and Drug Administration and the Department of Defense. Commander, USA Health Services Command, will provide and operate in compliance with terms of the license designated donor centers manufacturing locations and specifically designated products. All other USA Health Services Command medical treatment facilities will operate within the standards promulgated in Current Good Manufacturing Practices for Blood and Blood Components in the Code of Federal Regulations, Title 21, Part 606.

b. The command blood programs will provide continuing training opportunity for technical services skill development and maintain prepositioned blood equipment sets for contingencies/mobilization. Each medical treatment facility which uses, or expects to use, blood for patient care will establish a maximum capability for blood collection, processing, and storage to meet its own emergency needs and to support its mass casualty plans as well as applicable mobilization plans.

c. Guidance from the Office of the Assistant Secretary of Defense for Health Affairs states that the military departments will—

(1) Be prepared to support with blood a national emergency anywhere in the world in a rapid, efficient and adequate manner.

(2) Develop a departmental blood program that will support the department medical facilities.

(3) Insure the military blood programs support the Armed Forces Regional Health Services System; assist other Federal agency programs where feasible and prudent; seek ways to reduce CHAMPUS costs of blood.

(4) Cooperate fully and actively, after the military blood requirements are met, with the civilian blood banking community.

d. Commanders of medical treatment facilities will implement a policy of encouraging the replacement of blood and blood components used for patients not affiliated with military units. These patients are retired personnel, their dependents, and Veterans Administration beneficiaries. Patients should be encouraged to have a unit of blood deposited when the need can reasonably be anticipated, or deposited to replace one that has been used in treatment.

e. Each medical treatment facility which uses, or expects to use, blood for patient care will establish a maximum capability for blood collection, processing, and storage to meet its own emergency needs and to support its mass casualty plans as well as applicable mobilization plans.

f. Procurement of blood and blood components form other sources (when that provided by the command blood programs is insufficient) will be addressed in implementing instructions issued by those commanders identified in paragraph 12-4. Primary alternative utilization of other uniformed services' blood programs is expected, with secondary alternatives to be exchange arrangements with local civilian blood banks. When blood or blood components cannot be obtained from the above sources, they may be purchased from licensed blood centers at a rate prescribed in AR 40-330. Procurements

under national emergency standby contracts will be accomplished only by the DoD Military Blood Program Office and the Defense Logistics Agency.

g. Donors give blood with a full expectation that their living human tissue will be used for maintaining the life or improving the health of another human. In keeping this faith with the donor, extraordinary attention and effort must be used in avoiding waste (outdating) when at all possible. Managerial actions are a primary influence.

h. When outdating cannot be avoided, maximum value shall be salvaged from the donor's gift. Department of Defense policy regarding utilization of outdated blood is:

> "Military blood banking operations will result in the accumulation of varying amounts of whole blood which is not used prior to its expiration date. The constituents of this outdated blood remain as a source of valuable biologic products. As a matter of policy all appropriate and practicable means will be employed to ensure optimum conservation and utilization of these constituents."

Recovered Plasma Exchange Program agreements with commercial firms are authorized.

Note. At the time of the publication of this change, the Recovered Plasma Exchange Program was under study. As soon as the Program is revised, this regulation (AR 40–2) will be changed to announce the revision.

i. A records system will be developed and maintained to account for the acquisition, utilization, and disposition of all blood products to include recovered plasma assets in the medical blood programs as well as identifying all transient, acute, or chronic problems related to blood.

j. The medical blood programs related to the therapeutic use of blood and blood components, and the establishment and operation of transfusion services is beyond the scope of this chapter and will not be addressed.

12–4. Individual blood group and type. All individuals on active duty in the Army will have their blood group determined by both cell and serum grouping tests and their blood type determined by the use of Anti-Rho (D) serum. The results of the grouping tests will be recorded using the international (Landsteiner) classifications of "A," "B," "O," and "AB." The results of the Rh typing test will be recorded as "POS" or "NEG." The individual blood group and type is used primarily for identification purposes, but can serve as a convenience in donor pre-screening when only selected bloods are needed.

a. The accomplishment of blood grouping and typing in each organization is the responsibility of the commander.

b. The medical commander is responsible for the proper performance of the tests, and will insure that personnel performing the tests are properly trained and supervised.

c. Blood group and type determination will be made for all individuals processed through reception stations, training divisions, or similar organizations before transfer to other organizations. Blood group and type determinations for individuals not processed through such organization ordinarily will be made at the initial Army installation or organization where they report for duty provided facilities for performing the tests are available.

d. The commander of the medical treatment facility performing blood grouping of an individual will be responsible for insuring that the organization issuing the identification card DD Form 2A (Active Duty Military ID Card) and identification tag is informed of the correct blood group and type of the individual so that they may be properly recorded on the identification card and tag.

e. The blood type of an individual will be permanently entered on the Health Record folder in the space noted.

12–5. Overall responsibility. The Surgeon General will—

a. Discharge the responsibilities assigned to the Secretary of the Army in Department of Defense Directive 6480.5, June 16, 1972, paragraphs VI C and VI E.

b. Conduct research and develop programs devoted to progress and improvement in the areas of blood, blood derivatives, and plasma volume expanders and the techniques, facilities, and materiel related thereto in accordance with policy guidance from the Assistant Secretary of Defense for Health Affairs and the Under Secretary of Defense for Research and Engineering.

CHAPTER 13

ARMY MEDICAL DEPARTMENT VEHICLES

13–1. Purpose. This chapter describes Army Medical Department vehicles; prescribes the use of these vehicles; establishes policy pertaining to use of special equipment; and specifies requirement authorization for each type of vehicle.

13–2. Definitions. For the purpose of this chapter the following definitions apply:

a. Emergency medical service ambulance. A vehicle for emergency care which meets current Federal standards and—

(1) Can accommodate two emergency medical technicians and two litter patients, positioned so at least one patient can be given intensive life-support during transit.

(2) Carries equipment and supplies for optimal care at the emergency scene and during transport.

(3) Has two-way radio communication.

(4) Safeguards personnel and patients under hazardous conditions.

(5) Is designed for light rescue procedures and is constructed to afford maximum safety and comfort.

(6) Avoids aggravation of the patient's condition, exposure to complications, and threat to survival.

b. Field ambulance. A vehicle designed for transporting both emergency and non-emergency patients, litter or ambulatory, between field MTF which are equipped to provide minimum emergency care during transit.

c. Aerial ambulance. An aircraft assigned to an AMEDD unit which accommodates both litter and ambulatory patients who are seriously ill or injured and require rapid transport to field or fixed medical treatment units. An aerial ambulance is equipped to provide optimal emergency care en route.

d. Patient transport vehicle. A vehicle designed to move non-emergency ambulatory and litter patients between MTFs. It includes commercial type vans, automobile metropolitan, and inter-city buses.

13–3. General. AMEDD vehicles are designed for the primary purpose of transporting patients. Surface and aerial ambulances will be utilized to transport patients and medical department personnel and not to transport troops. Their use will be restricted to—

a. Transportation of sick, wounded, or injured persons who are eligible, by law or regulations, to receive medical care at an Army MTF or for humanitarian reasons.

b. Transportation of medical department personnel.

c. Transportation of supplies and equipment utilized in the care and treatment of the sick, wounded, or injured.

d. Instruction of personnel required to use ambulances.

13–4. Authorization. *a.* Emergency medical services ambulances are authorized for use as emergency medical treatment vehicles at fixed MTFs in accordance with the allowance system set forth in AR 310-34 and AR 310-49. There will be a minimum of two of these ambulances wherever life support vehicles are required.

b. Field ambulances are authorized for use at field MTF in accordance with the allowances in TDA or TOE.

c. Aerial ambulances are authorized for use at fixed or field MTFs in accordance with the allowances in TDAs, TOEs, or special authorization documents of Department of the Army.

d. Patient transport vehicles are authorized for use at fixed MTFs in accordance with the allowance system set forth in AR 310-34 and AR 310-49.

13–5. Operational control. AMEDD vehicles, to include aerial ambulances, will be assigned to and placed under the operational control of the commander of the AMEDD facility or medical unit responsible for their utilization.

★ 13–6. Ambulance marking. Instructions for marking ambulances are contained in the following publications:

a. Field ambulances, AR 746-1.

b. Emergency medical services ambulances, AR 58-1.

c. Patient transport vehicle (PTV). These vehicles are designed only to transport reclining or ambulatory patients who do not require emergency care or

intensive life-support during transit. These vehicles are not ambulances as defined in the Department of Transportation "Ambulance Design Criteria." These vehicles will not be marked AMBULANCE, have special identifying colors or be marked with the "Star of Life." Only emergency medical service ambulances will be identified in accordance with AR 58-1.

13–7. Warning devices. Warning devices will be utilized only on emergency medical services ambulances. Normally, their use will be restricted to proceeding to the scene of an emergency rather than returning to the MTF. Use of these devices does not give the operator of an ambulance authority to violate traffic regulations. Warning devices will include the following:

a. Warning lights consisting of a rotating roof mounted beacon and four flashing roof lights on the upper body corners.

b. Electronic siren system with selector control for the siren, public address, and radio amplification.

13–8. Spotlights and floodlights. Surface ambulances will be equipped with spotlights and/or floodlights as specified. This equipment will be for use only in emergencies.

13–9. Equipment. In addition to the equipment specified in the military and/or Federal specifications, ambulances will be supplied with medical items and other supplies for the care and treatment of patients as indicated below:

a. Emergency medical services ambulances will contain—

(1) A 12-volt dc two-way (mobile) radio, intercom, and public address system.

(2) Essential equipment as shown in appendix A. Additional medical equipment may be added at the discretion of the MTF commander.

b. Field ambulances will be equipped as indicated in the appropriate TOE or as dictated by the mission.

c. Aerial ambulances will contain—

(1) Essential equipment as shown in appendix C. Additional equipment may be added at the discretion of The Commander or as dictated by the mission.

(2) Equipped as indicated in the appropriate TOE, TDA, or special authorization document of The Department of the Army.

d. In no case will commercial off-the-shelf medical equipment be acquired or used unless determined by the Academy of Health Sciences, US Army, ATTN: HSA-ETE, Fort Sam Houston, TX 78234 to be suitable for aerial ambulance use.

e. Patient transport vehicles normally will not contain any special equipment.

CHAPTER 14

CONSUMER HEALTH PROGRAM

14–1. General. The excellence of inpatient and outpatient care and services by Army MTF is of continuous interest. Health care consumers are a valuable source of obtaining information regarding the adequacy of care, including ethics, aesthetics, timeliness, overall satisfaction, and appropriate avenues of redress. It is imperative that health care consumers have a better understanding of the Army health care delivery system, an opportunity to provide comments, and a method to have their views considered in the decision making process.

14–2. Purpose. The purpose of the Consumer Health Program is to—

a. Provide a communication means for transmittal of information, suggestions, and expressed concerns of the Army community about health services.

b. Improve health consumer education and information services.

c. Provide a means of conveying concern regarding health care entitlements, benefits, and changes thereto.

d. Provide plans and recommendations for implementation of new or projected services to meet the needs of the health consumer.

14–3. Consumer health input systems. Each MEDCEN/MEDDAC will utilize the following information sources to obtain consumer input:

a. Health care surveys/questionnaires.

b. Patient Affairs/Assistance Office inquiries.

c. Inspector general interview and complaint system.

d. Written correspondence from consumers.

e. Health Consumer Committee.

14–4. Health consumer committee. *a*. Each MEDCEN/MEDDAC will establish a Health Consumer Committee.

b. A majority of the committee members will be consumer representatives. A quorum of the entire committee will be considered present when three-fourths of the committee is present.

c. Composition and tenure of committee members:

★(1) *MEDCEN/MEDDAC Commander or designated representative—Chairman*. Tenure—duration of assignment. The chairman will designate one member to act as recorder.

(2) *DENTAC Commander—Deputy Chairman*. Tenure—duration of assignment.

(3) *Patient Affairs/Assistance Officer, if one is appointed*. Tenure—duration of assignment or employment.

(4) *Army Community Services Representative, as deemed appropriate*. Tenure—duration of assignment or employment.

(5) *Consumer representatives*. Committee will include the following categories of beneficiaries with the exact number of each to be determined by the Chairman.

(*a*) *Active duty personnel*. Enlisted and officer personnel will be appointed on a ratio equivalent to the enlisted/officer members comprising the patient population served by the MEDCEN/MEDDAC/DENTAC. Tenure should vary from 1 to 2 years.

(*b*) *Dependents* of active duty personnel, retirees, and dependents of retirees provided they are full-time Federal Government employees may serve as members. Tenure should vary from 1 to 2 years and is contingent upon continued full-time Federal employment.

★(6) *Other MEDCEN/MEDDAC/DENTAC representatives* as deemed appropriate by the Chairman.

d. Other dependents and retirees may be invited to present comments to the committee, but cannot serve as representatives and committee members.

Note: Committees intended for membership by anyone who is not a full-time officer or employee of the Federal Government will not be established without prior approval of the Secretary of the Army. (Reference: AR 15-1 and PL 92-463.)

e. The MEDCEN/MEDDAC commander should request assistance from the post installation commander in obtaining consumer representatives.

f. The committee should meet as necessary, but it is required to meet at least quarterly.

g. A copy of the committee report (minutes) will be forwarded to the medical command of each MEDCEN/MEDDAC.

★ **14–5. Responsibilities.** *a. Health Consumer Committee.* The responsibility of the committee is to recommend to the MEDCEN/MEDDAC and DENTAC commander ways to improve health care provided to the military community.

b. MEDCEN/MEDDAC/DENTAC.

(1) Evaluate consumer input.

(2) Take corrective action on comments/recommendations that are within the MEDCEN/MEDDAC/DENTAC scope of authority.

(3) Develop procedures/means to provide response to all the consumers served by the MTF.

c. Medical command.

(1) Review MEDCEN/MEDDAC Health Consumer Committee reports.

(2) Take corrective action on comments/recommendations that are within medical command scope of authority.

(3) Forward consumer comments/recommendations relevant to Department of the Army health policies through channels to HQDA(DASG-PSA), WASH DC 20310.

(4) Provide responses to consumer comments/recommendations to the MEDCEN/MEDDAC/DENTAC concerned.

d. HQDA (Office of The Surgeon General).

(1) Review comments/recommendations received.

(2) Consider comments/recommendations in the decision making process.

(3) Provide response to comments/recommendations to the medical command concerned.

★CHAPTER 15

MATERIEL DEMONSTRATIONS, EXAMINATIONS, EVALUATIONS, AND INQUIRIES

15–1. Purpose and scope. This chapter outlines the key provisions of section III, chapter 2, AR 40-61, concerning materiel inquires and investigation of commercially marketed equipment products for potential use by TDA medical facilities. It applies to all active Army medical and dental treatment facilities. It does not apply to clinical investigation activities, research and development activities, user testing of TOE equipment, or drugs, biologicals, reagents, medicated cosmetics, and toiletries.

15–2. Functional responsibility. The Directorate of Medical Equipment Test and Evaluation (DMETE), Academy of Health Sciences, US Army (AHS), Fort Sam Houston, TX 78234, manages the material evaluation and inquiry process in accordance with AR 40-61. It also is the AMEDD repository of medical equipment test and evaluation information.

15–3. Overview of the commercial item investigation and inquiry process. *a. Materiel demonstrations.* Demonstrations are the showing, use, or application of an item by the vendor and do not involve any action by Army personnel beyond observing the operation or use of the product by the vendor. Commanders of Army medical or dental activities may approve demonstrations as outlined in paragraph 2-10*a*, AR 40-61.

b. Materiel examination. Examinations are the use of an item by an activity, usually not to exceed 30 days, for the primary purpose of determining whether that or a similar item should be requested for purpose and future use. Examinations require product user information from DMETE, written agreement with the vendor, and an informal examination plan and report. Commanders of Army medical or dental activities may approve examinations when demonstrations are not adequate for determining the desirability of items for future use. Detailed procedures are covered in paragraph 2-10*b*, AR 40-61.

c. Materiel evaluations. Evaluations are formal investigations of materiel which may have AMEDD-wide potential to improve health care or efficiency and must be approved by The Surgeon General. Since user experience data becomes available rapidly after introduction of new items to the commercial market, and in consonance with Army policies to minimize testing of nondevelopmental items, evaluations will be approved on a limited case-by-case basis only. Materiel evaluation provisions include a comprehensive evaluation request, expanded product user information from DMETE, consideration of comparative item evaluation, written agreement(s) with the vendor(s), and formal evaluation protocol, milestone schedule, and report. Commanders of medical and dental activities may submit evaluation requests to DMETE as outlined in paragraph 2-10*c*, AR 40-61.

d. Materiel inquiries. DMETE provides a comprehensive information service for medical materiel and nonmedical materiel with medical implications for use in resolving materiel requirements. Although products are not recommended or endorsed, access to extensive Government and civilian information systems can provide market survey information, state-of-the-art developments, test and evaluation experience, and stock and availability data for standardized items. Inquiries may be submitted as outlined in paragraph 2-10*d*, AR 40-61.

APPENDIX A
ESSENTIAL EQUIPMENT FOR EMERGENCY MEDICAL SERVICES AMBULANCES

1. PORTABLE SUCTION APPARATUS, with wide-bore tubing and rigid pharygeal suction tip.
2. BAG-MASK VENTILATION UNIT, hand/operated, with adult, child, and infant size masks. Clear masks are preferable. Valves must operate in cold weather, and unit must be capable of use with oxygen supply.
3. OROPHARYNGEAL AIRWAYS, adult, child, and infant sizes.
4. MOUTH-TO-MOUTH ARTIFICIAL VENTILATION AIRWAYS, for adults and children.
5. PORTABLE OXYGEN EQUIPMENT, with adequate tubing and semi-open, valveless, transparent masks in adult, child, and infant sizes.
6. MOUTH GAGS, either commercial or made of three tongue blades taped together and padded.
7. STERILE INTRAVENOUS AGENTS, with administration kits.
8. UNIVERSAL DRESSINGS, approximately 10″ by 36″, compactly folded and packaged in convenient size.
9. STERILE GAUZE PADS, 4″ x 4″.
10. BANDAGES, soft roller, self-adhering-type, 6″ by 5 yards.
11. ALUMINUM FOIL, roll, 18″ x 25′, sterilized and wrapped.
12. ADHESIVE TAPE, two rolls, 3″ wide.
13. BURN SHEETS, two, sterile.
14. TRACTION SPLINT, lower extremity.
15. PADDED BOARDS, two or more, 4½ feet x 3″ wide.
    PADDED BOARDS, two or more, 3 feet long, of material comparable to 4-ply wood for coaptation splinting of leg or thigh.
16. PADDED WOODEN SPLINTS, two or more, 15″ x 3″, for fractures of the forearm. (Wire-ladder splints may be submitted.)
17. INFLATED SPLINTS, for extremities.
18. SPINE BOARDS, short and long, with accessories.
19. TRIANGULAR BANDAGES.
20. SAFETY PINS, large size.
21. SHEARS, BANDAGE.
22. OBSTETRICAL KIT, sterile.
23. POISON KIT.
24. BLOOD PRESSURE MANOMETER, CUFF, and STETHOSCOPE.

APPENDIX B

QUADRIPARTITE STANDARDIZATION AGREEMENT (QSTAR) 471

B–1. The Armies of the United States, United Kingdom, and Australia and the Canadian Forces have agreed to use supplementary labels for dispensed medicines within a wartime theater of operations in which members of two or more participating armies are deployed. The subscribing armies further agree to consult and in every possible case reach mutual agreement before introducing changes which affect the use of supplementary labels. The criteria to determine whether a supplementary label is necessary for a dispensed medicine is to prevent or allay drug reactions and to ensure that medication is taken in the most effective manner when there is some specified requirement concerning dosage regimen.

B–2. Some examples of possible areas of drug reactions and suggested wording of supplementary labels are as follows:

Drug Group—Areas of Reaction	Labels
1. (a) Sedatives, tranquilizers, antidepressants (b) Antihistamines (c) Narcotic analgesics	1. "This medication may cause drowsiness. If affected, do not drive a vehicle or operate machinery. AVOID ALCOHOL."
2. (a) Hypnotics and sedatives when they are ordered as a night-time dose (b) Oral Hypoglycemic drugs (c) Monoamine Oxidase inhibitors (d) Disulphiram	2. "Avoid taking alcohol with this medication unless advised by prescriber."
3. To apply to oral antibiotics with the exception of doxycycline, minocycline, clindamycin and Amoxicillin	3. "This medication to be taken one hour before food and three hours after the evening meal."
4. Tetracyclines—The word "milk" to be deleted when prescribing Doxycycline, Minocycline, Amoxicillin	4. "Do not take this medication with milk, antacids or preparations containing iron."

5. Monoamine Oxidase Inhibitors	5. "Certain foods and drugs should not be taken with this medication." As well as above labeling the patient will be advised of foods which are to avoided.
6. Insulin, Ampicillin suspensions, etc.	6. "REFRIGERATE" DO NOT FREEZE
7. For items with short shelf life	7. DISCARD CONTENTS AFTER / /
8. Drugs which cause serious phototoxic reactions when patients receiving these drugs are exposed to sunlight—photosensitive reactions	8. "Avoid exposure to direct sunlight during the course of medication with this preparation."

Note: In addition labels normally affixed to medicinal preparations (e.g., SHAKE WELL BEFORE USING, FOR EXTERNAL USE ONLY, POISON, etc.) will be used, where appropriate.

★ APPENDIX C

ESSENTIAL EQUIPMENT FOR AERIAL AMBULANCES

1. PORTABLE SUCTION APPARATUS, with wide-bore tubing and pharygeal tips in adult, child, and infant sizes; electric-powered, AC/DC, rechargeable battery or 115V. [1]
2. BAG-MASK VENTILATION UNIT, hand-operated with clear adult, child, and infant size mask; valves operable in cold weather and unit capable of use with oxygen supply. [1]
3. OROPHARYNGEAL AIRWAYS, adult, child, and infant sizes. [1]
4. PORTABLE OXYGEN EQUIPMENT, with adequate tubing and semiopen, valveless, transparent masks in adult, child, and infant sizes; positive pressure (with capacity for 80cm water pressure), demand, vaporization, and metered flow capability. [1]
5. BITE STICKS.
6. STERILE INTRAVENOUS FLUIDS, with administration kits; Ringer's Lactate and others as appropriate in plastic bag containers. [2]
7. DRESSINGS, First aid, Field, 11 ¾″ sq.
8. BANDAGES, soft roller, self-adhering type, assorted widths.
9. ALUMINUM FOILS, 18″ x 25″, sterilized and wrapped.
10. ADHESIVE TAPE, 3″ x 5 yd.
11. BURN SHEETS, sterile.
12. TRACTION SPLINT, lower extremity, with ratchet device, hook and pile fasteners.
13. PADDED WOODEN SPLINT, 4½′ x 3″, 3′ x 3″, 15″ x 3″.
14. INFLATABLE SPLINTS, for extremities.
15. SPINE BOARDS, short and long, with accessories.
16. TRIANGULAR BANDAGES, 37″ x 37″ x 52″.
17. SAFETY PINS, large.
18. SCISSORS, BANDAGE, ANGULAR, 7¼″.
19. OBSTETRICAL KIT, sterile.
20. POISON KIT.
21. BLOOD PRESSURE MANOMETER, ADULT AND PEDIATRIC CUFFS, AND STETHOSCOPE.
22. COLD PACK, CHEMICAL.
23. BLANKET, COMBAT CASUALTY.
24. OTOSCOPE AND OPTHALMOSCOPE. [3]

See footnotes at end of appendix.

25. MONITOR, BLOOD PRESSURE, RESPIRATION, AND PULSE, digital display, AC/DC and battery operated, non-interfering with AVIONICS equipment.
26. INFANT TRANSPORT INCUBATOR/ISOLETTE, with oxygen, air transportable. [4]
27. LARYNGOSCOPE. [3]
28. CARDIOSCOPE/RECORDED MODULE AND DEFRIBRILLATOR. [3]
29. BUTTERFLY INTRAVENOUS INFUSION NEEDLES, 19, 21, 23 ga. [3]
30. LITTER STRAPS.
31. SCOOP LITTER, CONTRACTABLE, with capability of operation with aircraft rescue hoist. [5]
32. LITTER, SEMI-RIGID. [6]
33. BAGS, STABILIZING.
34. CATHETER, NG, SUCTION. [3]
35. APPLICATOR, wood, cotton-tipped.
36. TROUSERS, pneumatic, anti-shock type II (MAST TROUSERS).
37. SURGICAL CLAMPS.
38. ALCOHOL SWABS.
39. RAZOR BLADES.
40. AIR SICKNESS BAGS.
41. THERMOMETER, HUMAN, CLINICAL, ORAL, low reading and regular scales.
42. TOURNIQUET, non-pneumatic.
43. STERILE GLOVES, assorted sizes.
44. CERVICAL COLLARS, assorted sizes.
45. SAW, finger ring.
46. SURGICAL LUBRICANT. [3]
47. LITTER PADS.
48. BLANKET SET.
49. DRUG ADMINISTRATION KIT, with drugs, protocol dependent. [3]
50. WIRE FABRIC.
51. FLASHLIGHT.
52. AMMONIA INHALANT AMPULES.
53. AMYL NITRITE INHALANT AMPULES.
54. ANTIDOTE, NERVE AGENTS, INJECTOR.
55. ASPIRIN TABLETS.
56. BACITRACIN ZINC OPHTHALMIC OINTMENT.
57. DETERGENT, SURGICAL.

See footnotes at end of appendix.

58. DIPHENHYDRAMINE HYDROCHLORIDE CAPSULES.
59. MORPHINE INJECTION.
60. POVIDONE-IODINE SOLUTION.
61. BANDAGE, ADHESIVE, ¾" x 3".
62. BANDAGE, COTTON, ELASTIC.
63. CATHETER AND NEEDLE UNIT, IV, 16, 18, 20 ga.
64. DRESSING, FIRST AID, FIELD CAMOUFLAGED, 4" x 7".
65. DRESSING, FIRST AID, FIELD CAMOUFLAGED, 7½" x 8".
66. SKIN CLOSURE, ADHESIVE, SURGICAL, ¼" x 3".
67. SPONGE, SURGICAL, 2" x 2".
68. SPONGE, SURGICAL, 4" x 4".
69. AIRWAY, PHARYNGEAL, RUBBER, Small Adult.
70. BLADE, SURGICAL KNIFE, #11.
71. DEPRESSOR, TONGUE, WOOD.
72. FORCEPS, DRESSING, STRAIGHT, 5½".
73. HANDLE, SURGICAL KNIFE, #3.
74. SCISSORS, GENERAL SURGICAL STRAIGHT, 5½".
75. PENCIL, MECHANICAL.
76. DD Form 1380 (US Field Medical Card).
77. LITTER, FOLDING, RIGID POLE.

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[1] Child and infant sizes.
[2] Fluids other than ringers lactate and normal saline—only authorized for use by ALS personnel.
[3] Only for ALS personnel.
[4] Peacetime only—unless mission required.
[5] Required for stabilized patient transport with hoist capability/probably developmental.
[6] INTERIM ITEM—UNTIL CONTRACTABLE, hoist capable litter available.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) direct to HQDA (DASG–HCP) WASH, DC 20310.

By Order of the Secretary of the Army:

BERNARD W. ROGERS
General, United States Army
Chief of Staff

Official:

J. C. PENNINGTON
Brigadier General, United States Army
The Adjutant General

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PATIENTS' TRUST FUND - DAILY SUMMARY RECORD

For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

NAME OF MTF

PAGE _____ OF _____ PAGES

PATIENT'S NAME	REGISTER NUMBER	RECEIPTS				WITHDRAWALS			
		CASH		CHECKS		CASH		CHECKS	

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(Continue on Reverse)

Figure 6–1

PATIENT'S NAME	REGISTER NUMBER	RECEIPTS				WITHDRAWALS			
		CASH		CHECKS		CASH		CHECKS	

RECAPITULATION		DAILY ACTIVITY	CHANGE FUND VARIATION
BEGINNING BALANCE			
RECEIPTS	CASH		
	CHECKS		
TOTAL RECEIPTS			
WITHDRAWALS	CASH		
	CHECKS		
TOTAL WITHDRAWALS			
TOTAL CASH ON HAND			

TYPED NAME AND GRADE OF AUTHORIZED OFFICIAL	SIGNATURE	DATE

Figure 6–2