DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

Canc frp: Jul 2008

IN REPLY REFER TO

BUMEDNOTE 6150
BUMED-M3
19 Jul 2007

BUMED NOTICE 6150

From: Chief, Bureau of Medicine and Surgery
TO: Ships and Stations Having Medical Department Personnel

Subj: GUIDANCE FOR COMPLETING ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET (DD 2766) AND INTERIM CHANGE TO MANUAL OF THE MEDICAL DEPARTMENT ARTICLE 16-23 AND ARTICLE 16-63

Ref: (a) Manual of the Medical Department (MANMED), Articles 16-23 and 16-63
(b) BUMEDNOTE 6150 of 15 Oct 2003
(c) Joint Commission on Accreditation of Healthcare Organization Manual
(d) Navy Environmental Health Center Technical Manual 6490.00-1 September 2000, Implementing Guidance for Deployment Health Surveillance
(e) The Joint Chiefs of Staff Memorandum, MCM-0006-02 of 1 Feb 2002
(f) OPNAVINST 6120.3
(g) SECNAVINST 5211.5E

Encl: (1) Guidance for Completing Adult Preventive and Chronic Care Flowsheet (DD 2766)

1. Purpose. To provide updated guidance on the completion of the Adult Preventive and Chronic Care Flowsheet (DD 2766). This notice supersedes reference (a), MANMED article 16-23, paragraph (4)(d), left side, part 1. The first form filed will be the DD 2766, thus replacing the NAVMED 6150/20. This notice also supersedes MANMED article 16-63 and provides updated guidance on the completion of the Adult Preventive and Chronic Care Flowsheet (DD 2766). Reference (b) provides guidance for the NAVMED 6150/42 (3-2003), Pediatric Summary of Care.

2. Cancellation. BUMEDNOTE 6150 of 1 Sep 2000.

3. Background. The DD 2766 functions as a summary list, per reference (c), providing a concise overview of the patient's health status for active duty and reserve component service members, non-active reserve component members, adult beneficiaries, and civilian employees. The DD 2766 is the Department of the Defense (DOD) standard form in the outpatient medical record for recording essential individual medical readiness (IMR), and is to accompany the deploying service member, per references (d) and (e).

4. Policy. Documentation on the DD 2766 should be done as a result of a face-to-face patient encounter, incorporating historical information from both the medical record and the patient. Updating the DD 2766 is a critical step in the Periodic Health Assessment (PHA) process. All physicians, licensed independent health care practitioners, and

other support staff providing care to patients will update the DD 2766 at each clinical encounter, as indicated. Support staff may initiate the patient interview and data verification, updating those sections (i.e., diagnosis, medications, medical history, surgeries, family history, laboratory results retrieval, and counseling issues, etc.) determined to be within their scope of practice and training. Documentation on the DD 2766 must be in permanent blue/black ink, with the exception of where pencil entries are specified in enclosure (1), paragraphs 4a, 4g(3), 4g(8) and 4j of this Note. Errors in documentation should be corrected with a single line across the entry and initialed by the individual making the correction. Products such as liquid correction or correction tape cannot be used on primary source documents such as medical records.

5. Procedures: Per reference (f), the Service Member's DD 2766, at a minimum, will be reviewed annually as part of the PHA. When new entries are entered into an automated system, the provider may either reprint the form or add data onto the last paper form. When new copies are printed, old copies will be shredded per references (e) and (g) only after ensuring that all information has been incorporated onto the new form. A Hospital Corpsman or Medical Department Representative (MDR) will print a new form reflecting the updated information. Any information lacking in the AHLTA-generated DD 2766 (i.e., Chronic Illnesses, Hospitalizations/Surgeries, Counseling, Family History, Deployment History, over-the-counter medications, herbals, significant operative procedures, etc.) must be written onto the AHLTA-generated DD 2766 or onto an earlier version of the DD 2766. The DD Form 2766C (Adult Preventive and Chronic Care Flowsheet - Continuation Sheet) may be used as a continuation page.

6. Responsibility. All medical personnel shall be familiar with the information provided in this notice. The Occupational History/Risk, the Readiness and Pre-/Post-Deployment sections are completed for active and Reserve component service members only. Sections 1 through 4, 6 and 7 are completed at a minimum for civilian employees as appropriate for their occupational category.

7. Point of Contact. For policy questions contact CAPT Patricia Dorn at patricia.dorn@med.navy.mil, or (202) 762-3585, or DSN 762-3585. Forward other questions about the DD 2766 form to Ciel Lazo, BUMED Health Information Administrator, at e-mail Cielito.lazo@med.navy.mil, commercial telephone (202) 762-3145, or DSN 762-3145.

8. Forms

a. DD 2766 is available through the Navy supply system using S/N 0102-LF-984-8400 and the DD 2766C is available using S/N 0102-LF-984-9600 ordering through the Navy Forms OnLine Web site at: http://forms.daps.dla.mil, these forms may not be reproduced; they must be used in the "card stock" format. Additional guidance on completing the DD 2766 is available at: http://www-nehc.med.navy.mil/hp/cps/pha.htm.

b. SF 600, Medical Record - Chronological Record of Medical Care is available at: http://contacts.gsa.gov/webforms.nsf/0/4951AF308C046D9785256A3F0005BE96/$file/sf600.pdf and is authorized for local reproduction.

c. NAVMED 6230/4 (Rev. 1-2004), Adult Immunizations Record is available at: http://navymedicine.med.navy.mil/Files/Media/directives/navmed%206230-4.pdf and is authorized for local reproduction.

d. DD 2795. Pre-Deployment Health Assessment is available from http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2795.pdf and is authorized for local reproduction.

e. DD 2796, Post-Deployment Health Assessment is available from http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2795.pdf and is authorized for local reproduction.

9. Cancellation Contingency. Retain until incorporated into reference (a).

D. C. ARTHUR

Distribution is electronic only via the Navy medicine Web site at: http://navymedicine.med.navy.mil/default.cfm?seltab=directives

BUMEDNOTE 6150
19 Jul 2007

GUIDANCE FOR COMPLETING ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET (DD 2766)

1. AHLTA Generated DD 2766: At this time a fully functional Armed Forces Health Longitudinal Technology Application (AHLTA) generated DD 2766 has not been fielded. For example, it does not include hospitalizations or over-the-counter medication information. The AHLTA DD 2766 is a read only form which pulls information from other places in the AHTLA application. Until the fully functional version of the AHLTA DD 2766 is fielded, commands are required to complete and maintain a hard copy DD 2766 in the outpatient medical record. The hard copy DD 2766 may be an AHLTA electronically-generated DD 2766 or the card stock DD 2766, Adult Preventive and Chronic Care Flowsheet. Commands may use current AHLTA functionality to assist in generating an electronically-generated printout but must ensure all blank sections are filled in to complete the DD 2766.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Information Management (IM) Standard (IM 6.40) requires inclusion of a summary list of all significant diagnoses, procedures, drug allergies and medications in all outpatient medical records. The DD 2766 functions as a summary list to facilitate continuity of care over time for a single provider or among several providers in different settings. To support quality and safe patient care, it is important that this information be readily available to staff. In order to meet this JCAHO requirement, a complete and current hard copy DD 2766 will be maintained in all adult outpatient records until the electronic summary list version of AHLTA is fully functional across Navy Medicine.

Additionally, the AHLTA Health History module supports documentation of the information required in a summary list. For commands where AHLTA is available, the health history module for each patient shall be maintained by the patient's primary care provider. The healthcare team may refer JCAHO surveyors to the AHLTA Health History Module in addition to the hard copy DD 2766 to satisfy JCAHO Standard IM 6.40.

2. MRRS Generated 2766: If the Medical Readiness Reporting System (MRRS) is used, the DD 2766 will be automatically populated with any information stored in this electronic system. The MRRS generated DD 2766 sections do not all correspond with section numbers reflected in this note.

3. SAMS Generated 2766: If the Shipboard Non-Tactical Automated Data Processor (SNAP) Automated Medical System (SAMS) is used, the DD 2766 will be automatically populated with any information stored in this electronic system. If the activity captures data using SAMS, the DD 2766 print utility will populate the form. If the print utility is not utilized, record new data onto a paper DD 2766 and the NAVMED 6230/4 as applicable.

4. Completion of the DD 2766: Refer to section headings for appropriate entries. Each section not automatically populated will be completed as described below:

a. Section 1 – Allergies: Document both medication and environmental allergies. Ensure true allergies (not side effects) are documented. If the member does not have any allergies, list "N/A" in pencil. MRRS will automatically enter allergy data.

b. Section 2 – Chronic Illnesses: List current chronic medical conditions, and any significant past illnesses.

c. Section 3 – Medications: List current medications (prescription, over-the-counter, herbals, supplements, and performance enhancers) to include frequency and dose. If an automated system is used to generate this section, ensure non-prescription items are added.

d. Section 4 – Hospitalizations/Surgeries: List hospitalizations and all surgeries including dates, in chronological order.

e. Section 5 – Counseling: Date, age, and topic are completed during the PHA or when a health risk assessment is completed and the patient is counseled. Place the letter associated with the type of counseling given in the corresponding square (e.g., "F" for Fitness, Note: define and include all codes in this section). This is NOT to be used at every visit. Counseling occurring during routine visits is documented on the SF 600 using the Subjective/Objective/Assessment/Plan (SOAPP) format (the second "P" is for prevention counseling) at the time of that encounter. The counseling block is not intended to take the place of documentation on the SF 600, or assumed to be an official referral for further education at community based services. This section will require updates as health behaviors and status change.

f. Section 6 – Family History: In the larger block, fill in the family member's designation (for example, M = Mother) with the corresponding disease, using the key provided. Specify the types of illness/disease. Document the age of the family member at time of death, if deceased. The empty block provides space for documentation of more expansive family history.

g. Section 7 – Screening Exams: The DD 2766 reflects frequencies based upon the TRICARE Standard Benefit package and may exceed evidence-based recommendations established by the U.S. Preventive Services Task Force (USPSTF).

(1) Starting with the current year and patient's age, fill in the remainder of blocks 7c and 7d.

(2) Using the columns created by completing the blocks in 7c and 7d above, determine the patient's current and future screening exam requirements by filling in the circles under the "Dates" field (block 7e) to denote the next date the test is due.

(3) Pencil in the date the exam is ordered.

(4) Use ink when the exam is completed and the results are written on the form using the proper key codes ("N" if normal, "X" if abnormal, "E" if done elsewhere, "R" if the patient refused, or "N/A" if not indicated). Actual results are to be entered for weight, height, blood pressure and cholesterol.

(5) Update the DD 2766 every time preventive care is ordered or performed, or results are returned. Results of past screening exams may be entered retrospectively at the health care team's discretion.

(6) Occupational screening exams are highly dependent upon the patient's occupation and exposure history. If indicated, use blocks 7((20), (21), and (22)) to document occupational monitoring programs, e.g., hearing conservation, radiation, asbestos, lead, etc. Include date member was enrolled in and, if applicable, removed from the specific medical surveillance program(s). If unsure of which Medical Surveillance Programs service member is in, contact the Occupational Medicine (OM) Clinic (Ashore) or OM Point of Contact (Afloat) for your location. Ask the service member if they have any hearing problems or tinnitus (ringing in the ears). If they answer "yes" to either question, refer for a "Non-Hearing Conservation" audiogram.

(7) Blank lines are available for clinicians to document additional screening exams.

(8) If frequent screening is indicated, pencil the recommended frequency in the next column as a visual reminder.

h. Section 8 – Occupational History/Risks: Annotate with a brief description occupations and identified health hazards associated with those occupations; work site exposures from industrial hygiene surveys recommending medical surveillance. Annotate if the member is in the Personal Reliability Program (PRP) or in a flying status.

i. Section 9 – Immunizations: Immunizations must be documented in an approved electronic database that transmits to the Defense Eligibility Enrollment System (DEERS) and in the appropriate location in the medical record. For those activities using the hard copy DD 2766, disregard the immunizations section because it does not accommodate entry of all required data. To document the required information, use the NAVMED 6230/4 (Rev. 1-2004), Adult Immunizations Record; file this form under the DD 2766.

j. Section 10 – Readiness: Enter the required information and the dates in the appropriate spaces. Any readiness data already stored in MRRS or SAMS will pre-fill the DD 2766 when printed. Readiness laboratory results will be entered into the appropriate block in the Readiness Section. If personnel are on limited duty or awaiting a physical evaluation board, the date will be entered in the section labeled "Permanent Profile Change," otherwise disregard the Permanent Profile blocks 2 through 7. The optometry prescription is to be written in pencil directly below "Glasses/Gas Mask" and revised as necessary. The date of the most recent HIV draw will be documented in the HIV section. The Fitness section is to be used by the Primary Care Manager to

document when an active duty member is cleared for participation in the Physical Readiness Testing Program. Clearance is presumed to be good for 1 year, unless medical conditions change. If waivers are granted, the granting date and expected reevaluation date will be recorded.

k. Section 11 – Pre/Post Deployment History:

(1) Except for classified operations, document the deployment location as well as the completion date of the pre- and post-deployment evaluations. For classified operations, the record of deployment location will be maintained only in the personnel folder, along with any required pre- and post-deployment evaluations such as the DD 2795 (Pre-Deployment Health Assessment) and the DD 2796 (Post-Deployment Health Assessment) and DD 2900 (Post Deployment Health Reassessment).

(2) The "Chart Audit" section can be used for quality assurance documentation.