Navy Environmental Health Center

Technical Manual NEHC TM 6490.00-1–September 2000

IMPLEMENTING GUIDANCE FOR DEPLOYMENT HEALTH SURVEILLANCE

NAVY ENVIRONMENTAL HEALTH CENTER

BUREAU OF MEDICINE AND SURGERY

Table of Contents

Tools

GLOSSARY

1. Deployment: A deployment originates from an Operational Order whether that be from the Joint Chiefs of Staff, from the Unified Command (CINC), or from the service-specific command. A deployment involves U.S. Navy and Marine Corps personnel movement for 30 consecutive days or more to a land-based location outside the United States that does not have a permanent U.S. military medical treatment facility (funded by the Health Defense Program).

2. Deployment Health Surveillance (DHS): Health Surveillance as defined by the Centers for Disease Control and Prevention is the ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of Public Health practice, closely integrated with timely dissemination of this data to those who need to know and implies the continuing observation of all aspects of the occurrence and speed of disease (and injury) that are pertinent to its control. For purposes of this Technical Manual, DHS is defined as the regular or repeated collection, analysis, and dissemination of uniform health information for monitoring the health of the deployed population and for recommending appropriate interventions in a timely manner when necessary.

3. Disease: An interruption, cessation, or disorder of bodily functions, systems, or organs.

4. DNBI: Disease Non-Battle Injury (definition is self-explanatory).

5. Health Hazard/Health Threat: For purposes of this document, the terms health hazard and health threat will be used synonymously. A health hazard is a factor, condition or exposure (toxic chemical agent, physical agent, biomechanical stressor, or biologic agent) that is responsible for disease and/or injury. A health threat is an indication or a warning of probable disease and/or injury. Since both potentially portend similar consequences- that of disease and/or injury- and military intelligence tends to speak in terms of threats, the terminology health threat will be utilized to refer to those things that are responsible for disease and/or injury.

6. Injury: Bodily hurt, damage, or loss sustained.

7. Pre-Deployment Health Assessment Questionnaire: Standardized health assessment form which is completed by military or civilian personnel prior to their deployment into a designated theater of operation.

8. Post-Deployment Health Assessment Questionnaire: Standardized health assessment form, which is completed by military or civilian personnel prior to their redeployment from a designated theater of operation.

GLOSSARY

9. Risk Assessment: Risk assessment has been broadly defined as the methodology to predict the likelihood of numerous unwanted events (including injury and disease).

a. Health Risk Assessment is the process through which toxicology and other scientific data for non-chemical threats collected from animal studies and human epidemiological data are combined with information about the degree of exposure to quantitatively (or qualitatively) predict the likelihood that a particular adverse response will be seen in a specific human population. This assessment of risk utilizes various sources of data including exposure data, health outcome data, medical event reports, environmental baseline conditions data (on-scene sampling and monitoring), current medical intelligence from the Armed Forces Medical Intelligence Center (AFMIC), information from after action reports, etc. Often there is not enough information to define risk in a quantitative fashion, so risk has to be defined in a qualitative fashion such as “Extremely High to Extremely Low”.

b. Environmental Risk Assessment is the science and art of predicting the frequency of disease in a population based on actual or projected (modeled) environmental exposures.

c. Occupational Risk Assessment is the science and art of predicting the frequency of disease in a population based on actual or projected occupational exposures.

10. Risk Communication: The process of adequately and accurately communicating the magnitude and nature of potential environmental and occupational health risks to commanders and to service members.

SECTION 1
INTRODUCTION

This document provides technical guidance for the U.S. Navy and Marine Corps on roles, responsibilities, and procedures for conducting Deployment Health Surveillance (DHS). Health Surveillance includes identifying risk factors and the population at risk, recognizing and assessing hazardous exposures, recommending and initiating specific countermeasures, and monitoring health outcomes. A system for conducting health surveillance includes a means of identifying health risks and then a means of collecting, transmitting, analyzing, reporting, and storing individual and population health data. Specific areas addressed in this technical manual include:

- Health Risk Assessment and Risk Communication:
  - Pre and Post Deployment Briefs.
- Health Readiness and Surveillance:
  - Establishment of minimal, but optimal, health standards.
  - Gathering of individual health data: Procedures to complete and route Pre- and Post-Deployment Health Assessment Questionnaires.
  - Gathering of Population Health Data: Procedures to collect and report Disease, Non-Battle Injury (DNBI) data.
  - Instructions for collection of biological samples.
  - Instructions for collection of environmental and occupational exposure samples.
- Information Management:
  - Flow of information from the field to service specific hubs and Department of Defense (DOD) hubs where it can be analyzed and stored.

This is a dynamic document and is based on current and anticipated guidance from DoD, Joint Service, and Service-specific instructions. The tools presented to help implement this program are what are available right now and will change as technology advances and new tools are developed. This document will be revised to reflect those changes in policy or those advances in technology as they occur. It is encouraged that prior to a deployment this document be reviewed in its entirety to ensure the deploying command has the latest guidance on how to implement their DHS Program. An updated document can be found on the Deployment Medical Surveillance Web Page at the Navy Environmental Health Center (NEHC) at the following Internet address:

http://www-nehc.med.navy.mil/prevmed/epi/depsurv.htm

SECTION 2
APPLICATION

This technical manual applies to the following personnel:

- Personnel from Active and Reserve components of the U.S. Navy and Marine Corps who are attached to military units deployed for service-specific or joint operations.

- Military personnel from the other services under the jurisdiction of the Navy and/or Marine Corps.

- Non-military (civilian) personnel under the jurisdiction of Navy and/or Marine Corps.

SECTION 3
REFERENCES

(a) DoD Directive 6490.2, *Joint Medical Surveillance*, 30 AUG 97
(b) DoD Instruction 6490.3, *Implementation and Application of Joint Medical Surveillance for Deployments*, 7 AUG 97
(c) Health Affairs Policy 9900002, *Policy for Pre- and Post-deployment Health Assessments and Blood Samples*, 6 OCT 98
(d) Chairman of the Joint Chiefs of Staff Memorandum MCM-251-98, *Deployment Health Surveillance and Readiness*, 4 DEC 98
(e) Draft *Joint Service Instruction on Deployment Health Surveillance and Protection*, Date xxx 1999
(f) AFJI 48-110/AR 40-562/BUMEDINST 6230.15 1 NOV 1995, *Immunizations and Chemoprophylaxis*
(g) Secretary of Defense Memorandum, 18 MAY 1998 U07740/98, *Implementation of the Anthrax Program for the Total Force*
(h) Manual of the Medical Department, NAVMED P-117
(i) DoD Directive 6485.1, 19 MAR 1991, *Human Immunodeficiency Virus-1*
(j) Assistant Secretary of Defense (Health Affairs) Memorandum, 18 JUL 1996, *Casualty Identification Policy Reference Specimen Samples from the Health Record*
(k) BUMEDINST 6224.8, 08 FEB 93, *Tuberculosis Control Program*
(l) BUMEDINST 6220.12A, 21 OCT 98, *Medical Event Reports*
(m) Navy Environmental Health Center (NEHC) Home Page. NEHC maintains a Deployment Medical Surveillance Home Page that can be accessed at

http://www-nehc.med.navy.mil/prevmed/epi/depsurv.htm

Copies of all references cited in this manual will be available via this home page for downloading if needed.

SECTION 4
DEFINITION OF DEPLOYMENT
RELEVANCE TO THE NAVY AND MARINE CORPS

1. Definition of Deployment as delineated in reference (d): A deployment originates from an Operational Order whether that be from the Joint Chiefs of Staff, from the Unified Command (CINC), or from the service-specific command. A deployment involves U.S Navy and Marine Corps personnel movement for 30 consecutive days or more to a land-based location outside the United States that does not have a permanent U.S. military medical treatment facility (funded by the Health Defense Program).

2. In general, any Navy or Marine Corps Unit that meets the criteria delineated in this definition must adhere to the requirements outlined by DHS. However, the caveats included below from reference (d) define possible exceptions to applying all or part of the DHS requirements.

a. Routine shipboard operations that are not anticipated to involve field operations for over 30 continuous days are exempt from the requirements for completion of Pre- and Post-Deployment Health Assessment Questionnaires but are not exempt from the other requirements of DHS.

b. If the duration of deployment is uncertain, then all DHS requirements (Pre- and Post-Deployment Health Assessment Questionnaires, Health Readiness, DNBI Reporting, etc.) will be adhered to.

3. As this definition and the caveats apply specifically to the Navy and Marine Corps, the following interpretation is provided:

a. Navy and civilian personnel on deployed surface ships, including the amphibious ships, are exempt from doing the Pre- and Post-Deployment Health Assessment Questionnaires but must adhere to all other requirements of DHS. (This also pertains to deployed civilian personnel and military members from other services who are assigned permanently or temporarily as ship's personnel.)

b. Marine Corps personnel on deployed surface ships who have an uncertain deployment status must adhere to all the requirements of DHS including completion of the Pre- and Post-Deployment Health Assessment Questionnaires. Navy personnel assigned to these Marine Units must also adhere to all the requirements of DHS.

c. Due to their unique mission requirements, submarines are exempt from doing the periodic reporting requirements of DHS, and the personnel are exempt from completing the Pre- and Post-Deployment Health Assessment Questionnaires. However, the commands must adhere to all other applicable requirements of DHS to include the collection of DNBI data. At the completion of the deployment, the deployed

submarine command will do a one-time submission of this data as outlined in Section 7 of this document.

d. Uncertain Deployment Status: If deployment length is uncertain, then Commanding Officers of Navy and Marine Corps Units must adhere to all aspects of the DHS Program. However, if the Unit does deploy and the deployment turns out to be less than 30 days, then completion of the Post-Deployment Health Assessment Questionnaire is not required.

SECTION 5
THREAT ASSESSMENT, HEALTH RISK ASSESSMENT, RISK COMMUNICATION, AND RECOMMENDATION OF COUNTERMEASURES

1. It is the responsibility of the commanding officer for each deploying unit to ensure that service members receive pre-deployment health risk briefings by qualified medical personnel utilizing appropriate risk communication strategies. Ensuring that the appropriate medical information is included in these briefings and that it is effectively conveyed to the deploying forces involves the following actions:

a. Identifying Perceived Health Threats in the theater of operation. A health threat can be identified from exposure data, health outcome data, medical event reports, environmental baseline conditions data, current medical intelligence, after-action reports, etc.

b. Performing a Health Risk Assessment. A risk assessment has been broadly defined as the methodology to predict the likelihood of numerous unwanted events. A Health Risk Assessment is the evaluation of the potential risk that an identified threat poses to an individual's health, taking the probability of occurrence of that threat into account. Health Risk Assessment is the process through which toxicology and other scientific data for non-chemical threats collected from animal studies and human epidemiological data are combined with information about the degree of exposure to quantitatively (or qualitatively) predict the likelihood that a particular adverse response will be seen in a specific human population. This assessment of risk utilizes the various sources of data that were used to identify health threats including exposure data, health outcome data, medical event reports, environmental baseline conditions data (on-scene sampling and monitoring), current medical intelligence from AFMIC, information from after action reports, etc. Often there is not enough information to define risk in a quantitative fashion; therefore risk has to be defined in a more qualitative fashion such as "Extremely High to Extremely Low".

c. Communicating Risk. Risk communication involves reporting the nature, magnitude, and significance of health risks in the theater of operation to service members, commanders, health professionals, and other interested parties. This includes describing the potential or anticipated impact of possible threats on the service member's health.

d. Recommending Countermeasures. The last step in these pre-deployment briefings is to recommend proven countermeasures, or controls, that may be used by deploying individuals and/or operational commanders to reduce the risk presented by an identified threat. These countermeasures can include, but are not limited to, appropriate personal protective measures and use of personal protective equipment.

2. General Procedures for Creating and Conducting the Pre-Deployment Briefing:

SECTION 5
THREAT ASSESSMENT, HEALTH RISK ASSESSMENT, RISK COMMUNICATION, AND RECOMMENDATION OF COUNTERMEASURES

a. Medical staffs and local Preventive Medicine assets will provide operational commanders with a Health Risk Assessment that is based on the most current information on threats in the theater of operation. The Navy Environmental and Preventive Medicine Unit (NEPMU) that has cognizance over the area to which Navy and Marine Corps personnel will be deployed can assist in constructing a "regional" pre-deployment briefing after the deployment order has been issued. This briefing will be disseminated to all deploying units by message and be made available on the NEHC website and on the websites of the cognizant unified command. Specific areas of focus include:

(1) Risk for specific infectious diseases with a focus on the vectors of these diseases.

(2) Risk for environmental and occupational health associated disease or injury.

b. Medical Department Representatives (MDR) from individual deploying Units will be responsible for actually delivering the brief to operational commanders and deploying personnel. However, personnel from the NEPMUs can and will assist in the briefings as requested.

c. Other innovative strategies, such as pamphlets or booklets, may be used to get the preventive medicine message out to deploying personnel.

d. This Pre-Deployment Briefing must provide operational commanders a prioritized assessment of health risks, a list of recommended countermeasures to reduce the impact of the health risks, and a list of monitoring tools that can be utilized to measure potential environmental and occupational exposures that may impact the health and safety of the personnel under his leadership. These requirements can be included in the overall Preventive Medicine Strategies outlined in Annex Q of the Operational Plan.

SECTION 6
HEALTH READINESS

1. Pre-Deployment Phase: The MDR for any command or unit in a deploying status is responsible for the Health Readiness of every service member in that command. The MDR will ensure at check-in and at least annually thereafter, until detachment, that each service member in the command or unit meets the following requirements in accordance with the pertinent Navy Instruction(s):

a. That immunizations (Tool 1) are current:

(1) DOD Minimum Requirements: Tetanus/diphtheria, hepatitis A, MMR, polio, influenza, and typhoid in accordance with reference (f). Anthrax vaccine as directed by reference (g).

(2) Service-specific requirements, as required: Yellow fever, hepatitis B, and plague in accordance with reference (f).

(3) Deployment-specific requirements consistent with the threat: Meningococcal vaccine, Japanese encephalitis vaccine, and malaria chemoprophylaxis in accordance with reference (f).

b. A Tuberculosis skin test (PPD) administered within the past 12 months or, in the case of a previous PPD converter, there is documentation of a current evaluation in accordance with reference (k).

c. Physical Examinations and Qualifications (either general or special duty) are current in accordance with reference (h).

d. HIV Screening completed within the previous 12 months in accordance with reference (i). This serves the dual purpose of accomplishing HIV screening per reference (i) and meeting the pre-deployment sampling requirement per reference (b).

e. DNA sampling is on file in accordance with reference (j). If there is nothing in the medical record to indicate that this sampling was done, the DoD DNA Specimen Repository can be contacted to confirm prior sampling is on file:

DoD DNA Specimen Repository:

Telephone:	Commercial (301) 295-4379/4381
	DSN 295-4379/4381
FAX:	(301) 295-4388
E-mail:	afrssir@afip.osd.mil

f. Dental Status is confirmed Dental Class I or Dental Class II.

g. Medical record accompanying the deploying member contains the following:

(1) Blood type and Rh factor.

(2) Current medications and allergies.

(3) Immunization record.

(4) Adult Preventive and Chronic Care Flowsheet, DD Form 2766

http://www-nehc.med.navy.mil/downloads/hp/dd2766.pdf

h. Personnel have received or have immediate access to Personal Medical and Protective Equipment.

(1) Personal Medical Equipment includes prescription glasses (a minimum of two pair), gas mask inserts, hearing aids, and orthodontic equipment.

(2) Personal Protective Equipment includes respiratory and hearing protection, personal exposure dosimeters as necessary, and personal safety equipment required in the performance of duties.

2. Deployment Phase: Upon notification of a deployment, as defined in Section 4 of this document, a member's or a unit's MDR will ensure the following:

a. Immunizations (including deployment specific requirements) are current.

b. Members are adequately supplied with at least a 90-day supply of their prescribed chronic medications or any required chemoprophylaxis.

c. Members have received all required Personal Medical and Protective Equipment.

d. Pre-Deployment Health Assessment Questionnaires have been processed as required (Tool 2).

Note: Any problems identified on the Pre-Deployment Health Assessment Questionnaire will be properly evaluated and a final medical disposition made prior to the deployment of the service member.

3. Post-Deployment: Upon notification of redeployment/reassignment orders by the commanding authority, the cognizant command or unit MDR will ensure the following:

SECTION 6
HEALTH READINESS

a. Immunizations administered during the deployment are properly annotated in the medical record.

b. Post-Deployment Health Assessment Questionnaires have been processed as required prior to redeployment/reassignment (Tool 3).

c. Tuberculosis screening is performed within one year of redeployment.

d. A serum sample is collected for purposes of accomplishing annual HIV screening and, in addition, for meeting the post-deployment sampling requirement per reference (b).

Note: Any problems identified on the Post-Deployment Health Assessment Questionnaire must be properly evaluated at the earliest opportunity either in theater or at their home station. If unable to do the evaluation in theater, an entry shall be made in the health record that follow-up is required at the next cognizant Medical Treatment Facility (MTF). It is recommended that, if at all possible, reservists who are augmented to support operational missions be kept on active duty until this evaluation is completed.

SECTION 7
INFORMATION MANAGEMENT

1. Collection of DNBI Data and Reportable Medical Events: References (d) and (e) require the routine collection and reporting of all medical encounters through weekly DNBI reports and through Medical Event Reports.

a. DNBI Data:

(1) Deployed setting: It is required that DNBI data be collected and reported weekly in a deployed setting only.

(2) Non-deployed setting: In order to establish baseline health trends for the different units and in order to enable continuity of process and a seamless transition from the non-deployed to the deployed setting, it is strongly recommended that DNBI data be routinely collected in non-deployed as well as deployed settings by all cognizant medical units. Weekly submission of this data is not required in the non-deployed setting. Local medical authorities are responsible for collecting and analyzing this data in a non-deployed setting. It is recommended that the collected data be maintained locally for three years and then disposed of. The NEPMUs could be consulted to assist in analyzing this data if required.

b. Data entry, collection, transfer, analysis, and feedback:

(1) Operational Medical Units on deployment:

(a) DNBI Reports:

(i) Submit weekly DNBI Reports using the form and instructions in Tool 4. This form can be generated "stubby pencil" fashion or by using the DNBI Reporting Program (Microsoft Access based program) incorporated into the 3.0 version of the Navy Disease Reporting System (NDRS).

(ii) Perform local analysis of medical data and provide data-driven recommendations to operational commanders on preventive actions that will help reduce DNBI rates in their personnel.

(iii) Forward DNBI reports to the NEHC through the chain-of-command IAW theater information policy. The NEPMUs can access the NEHC database to download DNBI data and information relative to deployed Units in their respective Area of Responsibility (AOR).

(iv) DNBI Reports should be submitted in a timely manner (within one week of collection of data) with electronic or hard copies of the reports maintained by the Operational Medical Unit indefinitely.

(v) In the case where there are multiple reporting medical activities in the theater of operation, it is preferred that the DNBI data is consolidated centrally and submitted as one report to JTF Surgeon or CINC with a copy to NEHC and the cognizant NEPMU.

(vi) Methods of reporting DNBI data in order of preference from top to bottom are as follows:

1. Electronic transmission to NEHC via NDRS	**ndrs@nehc.med.navy.mil**
2. Download report to disc and send disc to NEHC via U.S. Mail, FEDEX, or UPS	Commanding Officer Navy Environmental Health Center Attn Head Epidemiology Department 2510 Walmer Avenue Norfolk Virginia 23513-2617
3. Hardcopy of report via FAX to NEHC	Commercial: (757) 462-9691 DSN: 253-9691 Addressee: Head, Epidemiology Department
4. Hardcopy of report via U.S. Mail, FEDEX, or UPS to NEHC	Commanding Officer Navy Environmental Health Center Attn Head Epidemiology Department 2510 Walmer Avenue Norfolk Virginia 23513-2617
5. Telephone transmission to NEHC	Commercial: (757) 462-5500 DSN: 253-5500 (Request the Epidemiology Department)

(b) Medical Event Reports

(i) Submit timely Medical Event Reports or Disease Outbreak Reports as required by reference (l) using either NDRS software or the "stubby pencil" forms shown in Tools 5 and 6. Reportable Medical Events are listed in Tool 7.

(ii) Forward Medical Event Reports to the cognizant NEPMU. If there is any question as to what NEPMU has cognizance, forward the Medical Event Report to NEHC utilizing the methods of reporting listed above. NEHC will forward the information to the appropriate NEPMU.

(iii) Provide feedback to Operational Commanders on the management of diseases requiring Medical Event Reports.

(2) NEPMUs:

(a) Provide feedback to Operational Medical Units on the

management of diseases requiring Medical Event Reports.

(b) Upon receipt of a Medical Event Report, forward a copy of the information to NEHC.

(3) NEHC:

(a) Functions as the DHS hub for the Navy.

(b) Receives, collects, and serves as the repository for DHS data collected on Navy and Marine Corps personnel that are deployed.

(c) Transfers DHS data to the Defense Medical Surveillance System (DMSS) at the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM).

(d) Conducts longitudinal analysis of deployment health surveillance data in order to provide objective assessments of health risk.

(e) Uses formal publications and the Internet to provide information about long-term health trends, updated health risk assessments, and revised health threat inventories. This information will be vital in recommending up-to-date preventive strategies to operational forces.

Note: The important issue here is that information must flow from the field so it reaches its ultimate destination which is the DMSS at USACHPPM. In any given deployment, the military forces could be made up of personnel from all services. In most cases, there will be one service designated with primary responsibility for the medical care provided to the deployed forces. It is this designated service that is responsible for ensuring that DNBI Reports and Medical Event Reports get forwarded to DMSS at USACHPPM. Each service will determine how that information will flow from the field to DMSS. This Technical Manual only provides guidance on how information should flow from Navy medical units in the field. The other services will have their own system of reporting the data.

SECTION 8
ENVIRONMENTAL AND OCCUPATIONAL EXPOSURE SURVEILLANCE

1. Whether engaged in major regional conflicts (combat) or deployed in stability and support operations, commanders are aware that there may be threats beyond that of an armed adversary. Deployed personnel can be exposed to toxic chemicals, either intentionally or incidentally, from air, water, and to a lesser extent, soil. Exposure may occur through inhalation, ingestion, or skin contact. These health effects may adversely impact mission performance and/or result in DNBI during deployments. Risk to environmental chemical exposures must be assessed and integrated into overall military operational risk management. Environmental and occupational exposure surveillance is driven by the identification of perceived health threats and by the performance of a health risk assessment that is done prior to the deployment. Those environmental and occupational threats that are deemed significant ("moderate to extremely high" risk of causing health problems to military personnel) must be monitored in the field.

a. Threats deemed to be of "Extremely High" or of "High" risk must be assessed on-site with direct reading instrumentation.

b. Threats deemed to be of "Moderate" risk must be assessed off-site with rear laboratory support as required.

2. As an interim, USACHPPM TG 230A (Short Term Chemical Exposure Guidelines for Deployed Personnel) should be used for guidance on sampling methods and reference for those chemicals deemed "Extremely High" or "High" risk. The guidelines in TG 230A are intended solely for the use during military deployments and exercises outside the Unites States. They are not to be used to replace any Federal, State, local, or Navy standards applicable in non-deployed situations, such as continental United States training exercises. Specific industrial operations, (even those conducted during deployments) in which the conditions and frequency of exposures are similar to those in a base setting, should be evaluated using existing NAVOSH methods and standards. TG 230A can be accessed at:
http://chppm-www.apgea.army.mil/imo/ddb/dmd/DMD/TG/TECHGUID/TG230A.PDF

Each deployment will have different requirements for air, water, and soil sampling. Laboratory analysis may be available at the deployment site by mobile laboratories, real time instrumentation, and by specified DoD or contract laboratories.

The JTF Surgeon will direct specific information on the sampling policy, routing procedures, and reporting requirements.

If field analysis or real time instrumentation readings are conducted, as a minimum the following information should be documented:

a. Identification of the sample by a unique sample number or designation.

b. Site location where the sample was collected (GPS).

c. Media (air, water, soil, etc.) from which the sample was collected.

d. Sample results and who results were reported to.

e. Instrumentation used and calibration information.

f. Environmental conditions at the site where the sample was collected.

Consultative and technical assistance is available from the NEPMUs and NEHC on:

a. Completion of the occupational and environmental exposure health risk assessments which are just subparts of the overall Health Risk Assessment.

b. The equipment that is required to perform the environmental and occupational exposure monitoring and how and where can you find it.

c. The laboratory support that is available to help perform the testing of the samples collected in the field.

Note: There is a Joint Environmental Surveillance Working Group that is currently looking at issues pertaining to environmental and occupational exposure surveillance. Procedures are being developed to identify the personnel, equipment, and training that is necessary at the Forward Deployable Preventive Medicine Units in order to carry out this Occupational and Environmental Surveillance. When available, these changes will be included in future updates of this document.

SECTION 9
AFTER ACTION REPORTS

1. MDRs must comply with operation-specific guidance to document any environmental and occupational exposures during the deployment and any health lessons learned during the deployment. Documentation is in the form of official After-Action Reports such as the Joint Uniform Lessons Learned System, Cruise Reports, etc.

2. This timely feedback allows Medical personnel to provide Health Risk Assessments that are based on the most accurate and up-to-date information and intelligence available.

3. These reports should be submitted within 60 days of the conclusion of a deployment via the operational chain of command IAW theater information policy. Copies should be forwarded to the cognizant NEPMU and to NEHC.

SECTION 10
POST-DEPLOYMENT HEALTH DEBRIEF

1. It is the responsibility of the Commanding Officer of each deploying unit to ensure that service members receive a post-deployment health debriefing by qualified personnel utilizing quality risk communication strategies. The purpose is:

a. To provide information about health outcomes and exposures which may impact the member's health.

b. To address concerns of the member and the member's family.

2. In none of the references utilized to write this document is there any mention of a minimum time period for completing the Post-Deployment Health Brief upon return. However, the proposed USCINCPAC Instruction outlining their Joint Medical Surveillance Program recommends that it be completed at "re-deployment or immediately thereafter". There is some urgency to get this brief completed because the deployed personnel often get scattered in various directions following redeployment.

TOOL1
TABLE OF ADULT VACCINE DOSAGES AND ROUTES OF ADMINISTRATION

Vaccine	Initial Dose/Route	Repeat Dosing	Comments
Adenovirus (types 4 & 7)	1 dose orally of each	None	Recruits only
Anthrax	6 dose series, 0.5 ml SC: 1. Initial 2. 2 wks 3. 4 weeks 4. 6 months 5. 12 months 6. 18 months	0.5 ml SC every 12 months	Consult cognizant NEPMU for latest guidelines before administering
Cholera	1 dose, 0.5 ml SC or IM	Every 6 months if residing in or traveling to a highly endemic area	Consult cognizant NEPMU before administering
Haemophilus Influenza b	2 doses, 0.5 ml IM, 2 months apart	None	For asplenic accessions not previously immunized
Hepatitis A	Varies with vaccine preparation	Varies with vaccine preparation	Consult with cognizant NEPMU
Hepatitis B Recombinant Vaccine	3 doses, 1.0 ml IM, at 0, 1, and 6 months	None	For alternate dosing schedules, consult with cognizant NEPMU
Influenza	As directed by the annual message.		
JE Vaccine	3 doses, 1.0 ml SC, at 0, 7, and 30 days	1.0 ml SC every 3 years	For alternate dosing schedules, consult with cognizant NEPMU
Measles (monovalent or combination product)	1 dose, 0.5 ml SC	None	Two doses for adults born after 1957
Meningococcal (quadrivalent)	1 dose, 0.5 ml SC	Consult with cognizant NEPMU	May be required by some countries. Consult with cognizant NEPMU
Mumps	1 dose, 0.5 ml SC	None	None
Plague	3 dose series IM: 1. Initial - 1.0 ml 2. 1-3 mos later - 0.2 ml 3. 3-6 mos after #2 - 0.2 ml	0.2 ml IM at 6 and 12 months after the initial series. Every 1 to 2 years thereafter.	Consult with the cognizant NEPMU.

Vaccine	Initial Dose/Route	Repeat Dosing	Comments
Pneumococcal Polysaccharide	1 dose, 0.5 ml SC or IM	Consult with the cognizant NEPMU	For asplenic new accessions
Polio: IPV (Inactivated Poliovirus Vaccine)	1 dose, 0.5 ml SC	None	IPV only to personnel in close household or intimate contact with immunocompromised individuals
Polio: OPV (Live Poliovirus Vaccine)	1 dose, 0.5 ml orally	None	Do not give to adults who did not complete the OPV series as a child
Rabies: Post-Exposure Prophylaxis, no prior immunization	5 doses, 1.0 ml IM at 0, 3, 7, 14, and 28 days	None	Give dose 1 simultaneously with human rabies immune globulin. Consult with cognizant NEPMU
Rubella	1 dose, 0.5 ml SC	None	
Tetanus-Diptheria	1 dose, 0.5 ml SC or IM	0.5 ml SC or IM every 10 years or as indicated for wound management	Give adult series if no prior hx of immunization. 2 doses, 0.5 ml 4-8 weeks apart and a 3^{d} dose 6-12 months later
Typhoid (Live, attenuated Ty21a)	4 doses, one capsule PO on alternate days for a total of 4 capsules	Repeat the 4 dose series every 5 years	Capsules should be taken with cool liquids 1 hour before meals
Typhoid (ViCPS)	1 dose, 0.5 ml SC or IM	0.5 ml SC or IM every 2 years	
Varicella	2 doses, 0.5 ml SC given 4-8 weeks apart	None	Only for personnel with no prior immunization who lack hx of infection
Yellow Fever	1 dose, 0.5 ml SC or IM	0.5 ml SC or IM every 10 years	

Reference: BUMEDNOTE 6230 dated 20 APR 98

TOOL 2
PRE-DEPLOYMENT HEALTH ASSESSMENT QUESTIONNAIRE
GENERAL INSTRUCTIONS

1. Samples of the front and back pages of the Pre-Deployment Health Assessment Questionnaire are included here. Blank forms for the Pre-Deployment Health Assessment Questionnaire can be downloaded from the following web site:

http://amsa.army.mil/AMSA/amsa_ns_home.htm

2. Prior to entry into the theater of operations, deploying personnel must complete or re-validate their Pre-Deployment Health Assessment Questionnaire at their home station or processing station within 30 days of their deployment.

3. After the Questionnaire is administered, a health care provider must immediately review it. The person who administers the Questionnaire and does the initial review can be a medic or a corpsman. **However, it is mandatory that personnel who answer with positive responses to questions 2-4 and/or 7-8 be referred to a Physician, Physician Assistant, Nurse, or Independent Duty Corpsman for evaluation.**

4. Copies of the completed Questionnaires must be placed into the service member's permanent medical record. The **originals** will be immediately forwarded to the following address:

Army Medical Surveillance Activity
Attn: Deployment Surveillance
Bldg T-20, Rm 213 (MCHB-TS-EDM)
6825 16th Street, NW
Washington DC, 20307-5000

5. Medical providers should apply existing service standards and criteria in categorizing members as "Deployable" or "Not Deployable".

Note: There is currently no computerized version of this Questionnaire. Development of a one-sided version has been entertained but not approved. There is a plan to put this Questionnaire on pressure sensitive paper, but it has not happened as of this date. The two-sided version is available and must be completed with pen or pencil and submitted as hard copy.

33823

PRE-DEPLOYMENT Health Assessment

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

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

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

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

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

Demographics

Last Name

First Name **MI**

Deploying Unit

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

Social Security Number - -

DOB (dd/mm/yyyy) / /

Gender

- O Male
- O Female

Service Branch

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

Component

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

Pay Grade

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

Location of Operation

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

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

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

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

33823

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

Health Assessment

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

Please list your concerns: _____

_____

Service Member Signature

I certify that responses on this form are true. ☐

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

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

REFERRAL INDICATED

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

FINAL MEDICAL DISPOSITION: ○ **Deployable** ○ **Not Deployable**

Comments: (If not deployable, explain)

_____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp: ☐

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

End of Health Review

33823

DD FORM 2795, MAY 1999 ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

TOOL 3
POST-DEPLOYMENT HEALTH ASSESSMENT QUESTIONNAIRE
GENERAL INSTRUCTIONS

1. Samples of the front and back pages of the Post-Deployment Health Assessment Questionnaire are included here. Blank forms for the Post-Deployment Health Assessment Questionnaire can be downloaded from the following web site:

http://amsa.army.mil/AMSA/amsa_ns_home.htm

2. Service members must complete the Post-Deployment Health Assessment Questionnaire preferably in theater within 5 days prior to redeployment back to their home station.

3. After the Questionnaire is administered, a health care provider must immediately review it. The person who administers the Questionnaire and does the initial review can be a medic or a corpsman. **However, it is mandatory that personnel who answer with positive responses be referred to a Physician, Physician Assistant, Nurse, or Independent Duty Corpsman for evaluation.**

4. Copies of the completed Questionnaires must be placed into the service member's permanent medical record. The **originals** will be immediately forwarded to the following address:

Army Medical Surveillance Activity
Attn: Deployment Surveillance
Bldg T-20, Rm 213 (MCHB-TS-EDM)
6825 16th Street, NW
Washington DC, 20307-5000

Note: There is currently no computerized version of this Questionnaire. Development of a one-sided version has been entertained but not approved. There is a plan to put this Questionnaire on pressure sensitive paper, but it has not happened as of this date. The two-sided version is available and must be completed with pen or pencil and submitted as hard copy.

POST-DEPLOYMENT Health Assessment

33348

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

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

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

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

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

Demographics

Last Name

First Name **MI**

Deployed Unit

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

Social Security Number - -

DOB (dd/mm/yyyy) / /

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

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

Gender

- O Male
- O Female

Service Branch

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

Component

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

Pay Grade

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

Location of Operation

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

Deployment Location (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

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

33348

DD FORM 2796, MAY 1999 ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

33348

PLEASE FILL IN SOCIAL SECURITY # ___ - ___ - ____

Health Assessment

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

   Please list your concerns: _____

   _____

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

   Please list your concerns: _____

   _____

Service Member Signature

I certify that responses on this form are true. _____

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

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

REFERRAL INDICATED

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

EXPOSURE CONCERNS (During deployment)

Provider see questions 5&6 on this form

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

Comments: _____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp:

_____

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

End of Health Review

33348

DD FORM 2796, MAY 1999 ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

TOOL 4
WEEKLY DNBI REPORT
GENERAL INSTRUCTIONS

1. Determination of DNBI rates provides commanders and medical staffs an important tool at the unit level. They are the "vital signs of the unit," an early warning system for trouble. As the ultimate health outcome measure, abnormal DNBI rates can:

- Focus medical attention on a problem area.
- Reflect a failing command preventive medicine program.

2. Medical staffs use DNBI data to identify and highlight feasible means of reducing the incidence of preventable disease and injury. The data must be reported up the medical chain of command so that a "big picture" of disease patterns can be assembled to localize problems and dictate quick intervention with appropriate preventive medicine countermeasures. At every level of command, medical staffs use DNBI rates to provide operational commanders with a clear, information-supported picture of the command's health and medical readiness.

3. DNBI data must be reported on a weekly basis (ending Saturday 2359 hrs local) via the DNBI Reporting Program (Microsoft Access based program incorporated into the 3.0 version of NDRS). In the event computer support is not available, submit DNBI data using the method of reporting format in Section 7. DMSS provides the Joint Staff, unified commands, and the Services with periodic DNBI trend analysis reports for current deployments. A copy of the approved form (template) for the Weekly DNBI Report is included for reference. Blank forms for the DNBI Report can be downloaded from the following web site:

http://cba.ha.osd.mil

4. The DNBI Report summarizes weekly DNBI rates and provides baseline rates for comparison. This system depends on a proper sick call logbook or its electronic equivalent, which MUST record at a minimum the following information on EVERY patient encounter:

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

b. Type of visit - new, follow-up, or administrative.

c. Primary complaint.

d. Final diagnosis.

e. For injuries, a classification into recreation/sports, Motor Vehicle Accident (MVA), work/training, or other.

f. Final disposition into one of the following categories:

(1) Full duty.

(2) Light duty (estimated number of days).

(3) Sick in quarters (estimated number of days).

(4) In-patient admission.

g. DNBI category ("case definitions" provided at the end of this section).

5. Medical activities will retain sick call logbooks or their electronic equivalents at conclusion of the deployment.

General Guidelines for Filling Out the Weekly DNBI Report

1. Record the administrative data in the spaces provided at the top of form. The "Troop Strength" refers to the number of deployed personnel being taken care of by the reporting medical unit. Obtain average troop strength for the reporting period from the G-1/N-1/S-1/J-1. If the deployed unit includes *female* Service members, obtain an average *female* troop strength for determining gynecological rates.

2. Review the sick call log and add up total number of **new** cases (*excluding follow-ups*) seen during the entire week in each DNBI category. All new cases will fall under at least one of the categories as described in the "case definitions". If a patient has more than one new diagnosis and each diagnosis falls in a different category, then count each of the new diagnoses in their appropriate category. *Note: patients who are seen for follow-up and/or administrative evaluations fall into a different category than new cases.* Add up the total number of cases in each DNBI category and record the number in the space provided.

3. To calculate the DNBI rates, divide the total number of new cases in each category by the average troop strength and multiply by 100. For Gynecologic rates, divide the total number of new cases in the gynecologic category by the *female* troop strength and multiply by 100. Remember to always calculate an overall "Total DNBI" rate.

TOOL 4
WEEKLY DNBI REPORT
GENERAL INSTRUCTIONS

Example. If there were 20 new dermatological cases during the indicated week and the average troop strength was 500, the Dermatological Category Disease Rate for that week would be calculated as follows:

$$\frac{\text{20 new dermatological cases}}{\text{500 troops}} = 0.04, \text{ then } 0.04 \times 100 = 4\%$$

4. Next, fill in the appropriate block for the total number of estimated light duty days, lost duty days, and/or in-patient admissions for each category.

5. Perform unit-level analysis of the collected data:

a. Compare the calculated rate for each category with the suggested reference rate for that category. Comment is required under the sections "Problems Identified" and "Corrective Actions" for any category whose calculated rate exceeds that of the suggested reference rate.

b. When comparing rates, keep the following information in mind:

(1) The suggested reference rates are approximate and should be used only as a rough guide. Only the CINC Surgeon or JTF Surgeon may modify the "Suggested Reference Rates" based upon theater specific trends and/or preventive medicine guidance.

(2) Exceeding a rate by 0.1% is not necessarily an indication of a significant problem. However, going from half the suggested rate to twice the suggested rate probably indicates there is a health problem needing immediate attention.

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

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

TOOL 4
WEEKLY DNBI REPORT
GENERAL INSTRUCTIONS

6. Report weekly DNBI data to the unit commander and to medical personnel at higher echelons.

Notes:

- Count only the **initial** visit. *Follow-up visits are counted in the "Miscellaneous/Administration/Follow-Up" category.*
- All initial sick call visits will be placed in a category.
- If in doubt about which DNBI category, make the best guess.
- Estimate days of light duty, lost workdays, or admissions resulting from initial visits.

TOOL 4
WEEKLY DNBI REPORT
CASE DEFINITIONS

1. Combat/Operational Stress Reactions - Acute reaction to stress and transient disorders that occur without any apparent mental disorder in response to exceptional physical and mental stress.

Includes: Acute Situational Stress Reactions, Battle Fatigue, Post Traumatic Stress Disorder (PTSD), etc.
Excludes: Depression, Personality Disorders, etc.

2. Dermatological - Diseases of the skin and subcutaneous tissue.

Includes: Heat Rash, Fungal Infection, Cellulitis, Impetigo, Contact Dermatitis, Blisters, Ingrown Toenails, Unspecified Dermatitis, Sunburn, etc.

3. Gastrointestinal, Infectious - All diagnoses consistent with *infection* of the intestinal tract.

Includes: All types of Diarrhea, Gastroenteritis, "Stomach Flu", Nausea/Vomiting, Hepatitis, etc.
Excludes: Non-infectious intestinal diagnoses such as Hemorrhoids, Ulcers, etc.

4. Gynecological - Conditions related to the female reproductive system.

Includes: Complications of Pregnancy (bleeding, miscarriage, ectopic), *M*enstrual Abnormalities, Vaginitis, Pelvic Inflammatory Disease, etc.
Excludes: Pregnancy (captured under Administrative), STD's (separate category).

5. Heat/Cold Injuries – Injuries associated with Climatic and/or Other Environmental Conditions.

Includes: Heat Stroke, Heat Exhaustion, Heat Cramps, Dehydration, Hypothermia, Frostbite, Trench Foot, Immersion Foot, Chilblain, etc.

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

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

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

TOOL 4
WEEKLY DNBI REPORT
CASE DEFINITIONS

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

10. Ophthalmologic - Any acute diagnosis involving the eye.

Includes: Pinkeye, Conjunctivitis, Sty, Corneal Abrasion, Foreign Body, Acute Vision Problems, etc.
Excludes: Routine Referral for Glasses (non-acute), Blunt/Penetrating Trauma (categorized under one of the Injury categories).

11. Psychiatric, Mental Disorders - Any conventionally defined psychiatric disorders as well as any behavioral changes and/or disturbances of normal conduct which are either out of normal character or are coupled with unusual physical symptoms.

Excludes: Combat/Operational Stress Reactions.

12. Respiratory - Any diagnosis of the upper and/or lower respiratory tract.

Includes: Bronchitis, Pneumonia, Emphysema, Reactive Airway Disease, Pleurisy, "Common Cold"/URI, Laryngitis, Tonsillitis, Tracheitis, Otitis, Sinusitis, etc.

13. Sexually Transmitted Diseases - All sexually transmitted infections.

Includes: Chlamydia, HIV, Gonorrhea, Syphilis, Herpes, Chancroid, Venereal Warts, etc.
Excludes: Pelvic Inflammatory Disease (categorized under Gynecologic).

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

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

16. Dental - Any disease of the teeth and/or oral cavity.

Includes: Periodontal and Gingival Disorders, Caries, and Mandibular Abnormalities, etc.
Excludes: Dental Trauma (categorized under appropriate trauma classification).

TOOL 4
WEEKLY DNBI REPORT
CASE DEFINITIONS

17. Miscellaneous/Administration/Follow-up - All other visits to the treatment facility not fitting one of the above categories.

Includes: Profile Renewals, Pregnancy (initial diagnosis, prenatal care, awaiting evacuation), Immunizations, Prescription Refills, Physical Exams, Laboratory Tests for Administrative Purposes, etc.

18. Definable – An additional category of Public Health concern that is established for a specific deployment (e.g., malaria, dengue, airborne/HALO injuries, etc.). Authorization to establish a category with a definable case definition resides at a level of authority equal to or higher than the JTF Surgeon/Task Force Surgeon. (The use of one of these categories assumes consultation with appropriate preventive medicine personnel.)

TOOL 4
DISEASE NON-BATTLE INJURY REPORT

Unit/Command: _____ Troop Strength: _____

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

Individual Preparing Report: _____
Phone _____E-mail _____

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

Dental		xxxxxx		x x			
Misc/Admin/Followup		xxxxxx		x x			
Definable				x x			
Definable				x x			

Problems Identified:
_____
_____
_____

Corrective Actions:
_____
_____
_____

TOOL 5
MEDICAL EVENT REPORT FORMAT

Reference: BUMEDINST 6220.12A dated 21 OCT 98

Submit medical event reports via the NDRS software program. In the rare event computer support is not available, submit medical event reports using the following format:

1. Date:

2. Reporting Command and UIC :

3. POC:
   Address:
   Telephone (commercial and DSN, as applicable):
   E-mail:

4. Patient's Name:

5. Patient's Social Security Number:

6. Patient's Branch of Service:

7. Patient's Command and UIC:

8. Diagnosis (to include ICD-9 Code)*:

9. Diagnosis Suspected or Confirmed**:

10. Date of Onset of Symptoms:

11. Disposition***:

12. Comments (optional):

*Item 8: ICD-9 code should be solely used as the means of transmitting sensitive medical diagnoses by routine message traffic.

** Item 9: If the diagnosis was confirmed, state whether the diagnosis was based on clinical or laboratory findings.

***Item 11: Returned to full duty, sick in quarters, light duty, admitted, other. State the category and duration of the disposition (number of days, etc.).

TOOL 7
OUTBREAK REPORT FORMAT

Reference: BUMEDINST 6220.12A dated 21 OCT 98

Submit outbreak reports via the NDRS software program. In the rare event computer support is not available, submit outbreak reports using the following format:

1. Dates of Outbreak:

2. Reporting Command and UIC:

3. POC:
   Address:
   Telephone (commercial and DSN, as applicable):
   E-mail:

4. Report Status:

5. Diagnosis (to include ICD-9 code):

6. Number of People Affected:

7. Location of Outbreak:

8. Narrative:

   a. How were the cases defined?
   b. If the diagnosis was confirmed, was the diagnosis based on clinical and/or laboratory findings?
   c. Suspected/confirmed source of the outbreak?
   d. Preventive measures taken?
   e. Lessons learned?
   f. Follow-up?

9. Comments (optional):

TOOL 7
OUTBREAK REPORT FORMAT

Amebiasis	Listeriosis
Anthrax	Lyme Disease
Biological Warfare Agent Exposure	Malaria (All)
Botulism	Malaria, Falciparum
Brucellosis	Malaria, Malariae
Campylobacter	Malaria, Ovale
Carbon Monoxide Poisoning	Malaria, Unspecified
Chemical Agent Exposure	Malaria, Vivax
Chlamydia	Measles
Cholera	Meningococcal Disease
Coccidioidomycosis	Meningitis
Cold Weather Injury (All)	Septicemia
Frostbite	Mumps
Hypothermia	Pertussis
Immersion Type	Plague
Unspecified	Pneumococcal Pneumonia
Cryptosporidiosis	Poliomyelitis
Cyclospora	Q Fever
Dengue Fever	Rabies, Human
Diphtheria	Relapsing Fever
E. Coli 0157:H7	Rheumatic Fever, Acute
Ehrlichiosis	Rift Valley Fever
Encephalitis	Rocky Mountain Spotted Fever
Filariasis	Rubella
Giardiasis	Salmonellosis
Gonorrhea	Schistosomiasis
H. Influenzae, Invasive	Shigellosis
Hantavirus Infection	Smallpox
Heat Injuries	Streptococcus, Group A, Invasive
Heat Exhaustion	Syphilis (All)
Heat Stroke	Syphilis, Congenital
Hemorrhagic Fever	Syphilis, Latent
Hepatitis A	Syphilis, Primary/Secondary
Hepatitis B	Syphilis, Tertiary
Hepatitis C	Tetanus
Influenza	Toxic Shock Syndrome
Lead Poisoning	Trichinosis
Legionellosis	Trypanosomiasis
Leishmaniasis (All)	Tuberculosis, Pulmonary
Leishmaniasis, Cutaneous	Tularemia
Leishmaniasis, Mucocutaneous	Typhoid Fever
Leishmaniasis, Unspecified	Typhus Fever
Leishmaniasis, Visceral	Urethritis, Non-Gonococcal
Leprosy	Vaccine, Adverse Event
Leptospirosis	Varicella, Active Duty Only
	Yellow Fever

Source: Tri-Service Reportable Events: Guidelines and case Definitions, version 1.0, Jul 98