

Navy Expeditionary Mobilization Processing

Medical Brief



Navy Mobilization Processing Sites
(Norfolk, San Diego, Gulfport, Port Hueneme)



Medical Staff

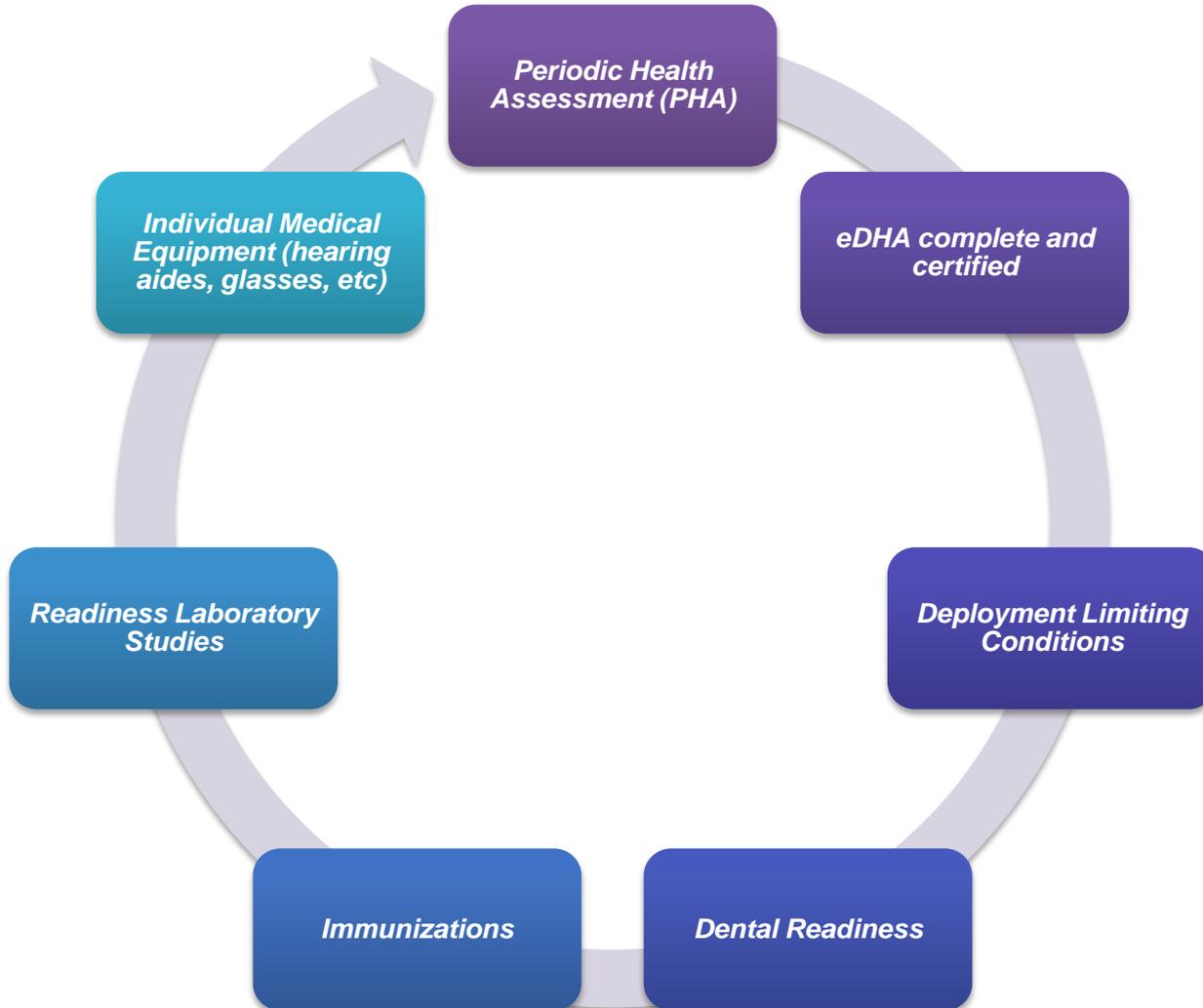


Senior Medical Officer

Corps Staff



The 7 Elements of IMR

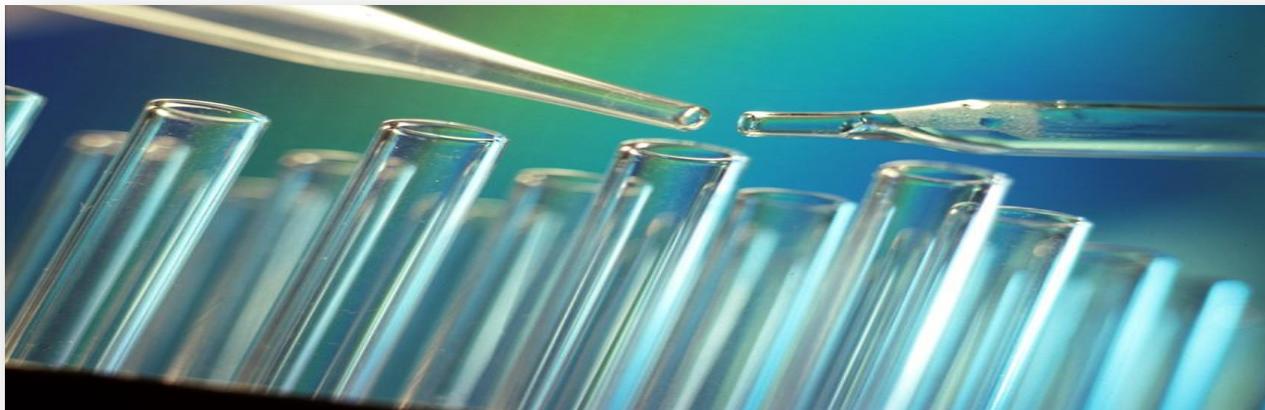




Labs

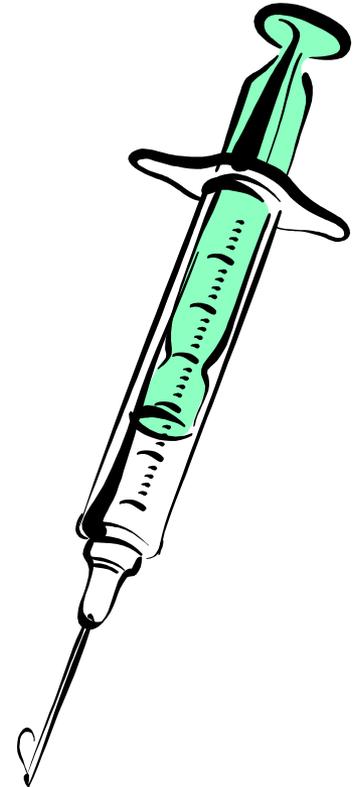


- ***Prior to arrival ALL LABS are researched in the NAVY'S Medical Databases (AHLTA/MMRS/HR).***
- ***If Labs are not found in the HR, MMRS, or ALTHA then SM will be scheduled for the required Labs.***



Immunizations

- ***Prior to arrival ALL IMM's are researched in the NAVY'S Medical Databases (MRRS/HR). ALTHA search is done during the Medical Requirements window on the schedule.***
- ***If IMM's are not found in the HR or the Databases, then SM will be scheduled to receive the Immunizations.***
- ***Small Pox is not given during the medical requirements schedule time. SP will be administered along with any live virus IMMZ after the provider visit.***





Pre-Deployment Considerations

- ***Deployment limiting conditions entered in MRRS***
- ***Disorders not meeting the threshold for a MEB (Medical Evaluation Board) should demonstrate a pattern of stability without significant symptoms for at least 3 months prior to deployment.***
- ***Ensure all labs, x-rays etc. are resulted prior to “deployable”***
- ***PHA and eDHA processes provide opportunity to identify conditions and concerns that would stop a service member from meeting Pre-deployment medical criteria.***
- ***Pre-deployment Health Assessment is designed to identify health concerns that would preclude deployment or require a brief course of treatment immediately prior to deployment.***

Medical Process

AFTER REVIEW OF THE BELOW THE PROVIDER MAY ELECT TO EXAMINE THE MEMBER, DRAW ADDITIONAL LAB TESTS, OR ORDER FURTHER STUDIES (X-RAY, MRI, ETC.)

THE MEMBER IS NOT CLEARED UNTIL THE DEPLOYMENT VERIFICATION FORM HAS BEEN COMPLETED AND SIGNED BY THE PROVIDER

Collect Medical and Dental Records

- Medical Records will be reviewed by staff for IMR accuracy

MRRS Review

Deployment verification (include snapshot)

- Form will be annotated with all deficiencies
- Deficiencies will be completed prior to provider visit

Provider Visit

- Review of medical record, AHLTA, and VA records
- Review of:
 - DD 2795 (Pre-deployment Health Assessment)
- PHA (Periodic Health Assessment)
- DD 2807-1 (Report of Medical History)
- NAVMED 1300/4
- AOR-specific forms if applicable

Need help with your **MEDICAL REFERRAL?**

The Resource Referral Tracking Manager is here to assist you with:

- ✓ Tracking issued referrals for returning RC and AC members
- ✓ Maintaining monthly contact until issues are resolved
- ✓ Problem solving appointment issues, delayed care, etc.
- ✓ Locating resources for TRICARE, VA, and civilian locations
- ✓ Helping you with understanding your health benefits

Resource Referral
TRACKING MANAGER

1 (855) NAVY 311
24/7 HOTLINE 1 (855) 628-9311

Need help accessing **TRICARE, VA or MTF?**

The Resource Referral Tracking Manager can answer your questions:

- ✓ TRICARE benefits are confusing and you need help?
- ✓ You're on terminal leave and an agency (VA, TRICARE, Medical Treatment Facility) states you're not eligible?
- ✓ You live in a remote area, on terminal leave and sprain your ankle?
- ✓ You arrive home and realize you forgot to tell the NMPS provider about a service related injury?
- ✓ Need help understanding your entitlements and benefits?
- ✓ Specific geographic location assistance?

Resource Referral
TRACKING MANAGER

1 (855) NAVY 311
24/7 HOTLINE 1 (855) 628-9311



DD 2807-1



REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.)			OMB No. 0704-0413 OMB approval expires Mar 31, 2010						
<p>The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Service Directorate (3204-013). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.</p> <p>PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.</p>									
<p>PRIVACY ACT STATEMENT</p> <p>AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346, and E.O. 9397 (SSAN). PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces. ROUTINE USE(S): None. DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.</p>									
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		2. SOCIAL SECURITY NUMBER		3. TODAY'S DATE (YYYYMMDD)					
4. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)			5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)						
b. HOME TELEPHONE (Include Area Code)									
<p>X ALL APPLICABLE BOXES:</p> <table border="0"> <tr> <td> 6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force </td> <td> <input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard </td> <td> 6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Retention <input type="checkbox"/> Separation </td> <td> 6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation </td> <td> 7.a. POSITION (Title, Grade, Component) 7.b. USUAL OCCUPATION <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program </td> </tr> </table>					6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Retention <input type="checkbox"/> Separation	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation	7.a. POSITION (Title, Grade, Component) 7.b. USUAL OCCUPATION <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Retention <input type="checkbox"/> Separation	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation	7.a. POSITION (Title, Grade, Component) 7.b. USUAL OCCUPATION <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program					
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)		9. ALLERGIES (Including insect bites/stings, foods, medicines or other substances)							
<p>Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in item 29 on Page 2.</p> <table border="0"> <tr> <td> 10. HAVE YOU EVER HAD OR DO YOU NOW HAVE: 10.a. Tuberculosis b. Lived with someone who had tuberculosis c. Coughed up blood d. Any of any breathing problems related to exercise, weather, pollution, etc. e. Shortness of breath f. Bronchitis g. Wheezing or problems with wheezing h. Been prescribed or used an inhaler i. A chronic cough or cough at night j. Sinusitis k. Hay fever l. Chronic or frequent colds 11.a. Severe tooth or gum trouble b. Thyroid trouble or goiter c. Eye disorder or trouble d. Ear, nose, or throat trouble e. Loss of vision in either eye f. Worn contact lenses or glasses g. A hearing loss or wear a hearing aid h. Surgery to correct vision (RK, FRK, LASIK, etc.) 12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) b. Arthritis, rheumatism, or bursitis c. Recurrent back pain or any back problem d. Numbness or tingling e. Loss of finger or toe </td> <td> 12. (Continued) f. Foot trouble (e.g., pain, corns, bunions, etc.) g. Impaired use of arms, legs, hands, or feet h. Swollen or painful joints i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) j. Any knee or foot surgery including arthroscopy or the use of a scope k. Any need to use corrective devices such as prosthetic devices, low back brace, back support, etc. or orthosis, etc. l. Bone, joint, or other deformity m. Plate(s), screw(s), rod(s) or pin(s) in any bone n. Broken bone(s) (cracked or fractured) 13.a. Frequent indigestion or heartburn b. Stomach, liver, intestinal trouble, or ulcer c. Gall bladder trouble or gallstones d. Jaundice or hepatitis (liver disease) e. Rupture/bleeding f. Rectal disease, hemorrhoids or blood from the rectum g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) h. Frequent or painful urination i. High or low blood sugar j. Kidney stone or blood in urine k. Sugar or protein in urine l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital wart, herpes, etc.) 14.a. Adverse reaction to serum, food, insect stings or medicine b. Recent unexplained gain or loss of weight c. Currently in good health (If no, explain in item 29 on Page 2.) d. Tumor, growth, cyst, or cancer </td> </tr> </table>					10. HAVE YOU EVER HAD OR DO YOU NOW HAVE: 10.a. Tuberculosis b. Lived with someone who had tuberculosis c. Coughed up blood d. Any of any breathing problems related to exercise, weather, pollution, etc. e. Shortness of breath f. Bronchitis g. Wheezing or problems with wheezing h. Been prescribed or used an inhaler i. A chronic cough or cough at night j. Sinusitis k. Hay fever l. Chronic or frequent colds 11.a. Severe tooth or gum trouble b. Thyroid trouble or goiter c. Eye disorder or trouble d. Ear, nose, or throat trouble e. Loss of vision in either eye f. Worn contact lenses or glasses g. A hearing loss or wear a hearing aid h. Surgery to correct vision (RK, FRK, LASIK, etc.) 12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) b. Arthritis, rheumatism, or bursitis c. Recurrent back pain or any back problem d. Numbness or tingling e. Loss of finger or toe	12. (Continued) f. Foot trouble (e.g., pain, corns, bunions, etc.) g. Impaired use of arms, legs, hands, or feet h. Swollen or painful joints i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) j. Any knee or foot surgery including arthroscopy or the use of a scope k. Any need to use corrective devices such as prosthetic devices, low back brace, back support, etc. or orthosis, etc. l. Bone, joint, or other deformity m. Plate(s), screw(s), rod(s) or pin(s) in any bone n. Broken bone(s) (cracked or fractured) 13.a. Frequent indigestion or heartburn b. Stomach, liver, intestinal trouble, or ulcer c. Gall bladder trouble or gallstones d. Jaundice or hepatitis (liver disease) e. Rupture/bleeding f. Rectal disease, hemorrhoids or blood from the rectum g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) h. Frequent or painful urination i. High or low blood sugar j. Kidney stone or blood in urine k. Sugar or protein in urine l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital wart, herpes, etc.) 14.a. Adverse reaction to serum, food, insect stings or medicine b. Recent unexplained gain or loss of weight c. Currently in good health (If no, explain in item 29 on Page 2.) d. Tumor, growth, cyst, or cancer			
10. HAVE YOU EVER HAD OR DO YOU NOW HAVE: 10.a. Tuberculosis b. Lived with someone who had tuberculosis c. Coughed up blood d. Any of any breathing problems related to exercise, weather, pollution, etc. e. Shortness of breath f. Bronchitis g. Wheezing or problems with wheezing h. Been prescribed or used an inhaler i. A chronic cough or cough at night j. Sinusitis k. Hay fever l. Chronic or frequent colds 11.a. Severe tooth or gum trouble b. Thyroid trouble or goiter c. Eye disorder or trouble d. Ear, nose, or throat trouble e. Loss of vision in either eye f. Worn contact lenses or glasses g. A hearing loss or wear a hearing aid h. Surgery to correct vision (RK, FRK, LASIK, etc.) 12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) b. Arthritis, rheumatism, or bursitis c. Recurrent back pain or any back problem d. Numbness or tingling e. Loss of finger or toe	12. (Continued) f. Foot trouble (e.g., pain, corns, bunions, etc.) g. Impaired use of arms, legs, hands, or feet h. Swollen or painful joints i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) j. Any knee or foot surgery including arthroscopy or the use of a scope k. Any need to use corrective devices such as prosthetic devices, low back brace, back support, etc. or orthosis, etc. l. Bone, joint, or other deformity m. Plate(s), screw(s), rod(s) or pin(s) in any bone n. Broken bone(s) (cracked or fractured) 13.a. Frequent indigestion or heartburn b. Stomach, liver, intestinal trouble, or ulcer c. Gall bladder trouble or gallstones d. Jaundice or hepatitis (liver disease) e. Rupture/bleeding f. Rectal disease, hemorrhoids or blood from the rectum g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) h. Frequent or painful urination i. High or low blood sugar j. Kidney stone or blood in urine k. Sugar or protein in urine l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital wart, herpes, etc.) 14.a. Adverse reaction to serum, food, insect stings or medicine b. Recent unexplained gain or loss of weight c. Currently in good health (If no, explain in item 29 on Page 2.) d. Tumor, growth, cyst, or cancer								

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		SOCIAL SECURITY NUMBER			
<p>Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in item 29 below.</p> <table border="0"> <tr> <td> 15. HAVE YOU EVER HAD OR DO YOU NOW HAVE: 15.a. Dizziness or fainting spells b. Frequent or severe headache c. A head injury, memory loss or amnesia d. Paralysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meningitis, encephalitis, or other neurological problems 16.a. Rheumatic fever b. Prolonged bleeding (as after an injury or tooth extraction, etc.) c. Pain or pressure in the chest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure 17.a. Nervous trouble of any sort (anxiety or panic attacks) b. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble sleeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs </td> <td> 19. Have you been refused employment or been unable to hold a job or stay in school because of: a. Sensitivity to chemicals, dust, sunlight, etc. b. Inability to perform certain motions c. Inability to stand, sit, kneel, lie down, etc. d. Other medical reasons (If yes, give reasons.) 20. Have you ever been treated in an Emergency Room? (If yes, for what?) 21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) 22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) 23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) 24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) 25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) 26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) 27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) 28. Have you ever been denied life insurance? </td> </tr> </table>				15. HAVE YOU EVER HAD OR DO YOU NOW HAVE: 15.a. Dizziness or fainting spells b. Frequent or severe headache c. A head injury, memory loss or amnesia d. Paralysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meningitis, encephalitis, or other neurological problems 16.a. Rheumatic fever b. Prolonged bleeding (as after an injury or tooth extraction, etc.) c. Pain or pressure in the chest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure 17.a. Nervous trouble of any sort (anxiety or panic attacks) b. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble sleeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs	19. Have you been refused employment or been unable to hold a job or stay in school because of: a. Sensitivity to chemicals, dust, sunlight, etc. b. Inability to perform certain motions c. Inability to stand, sit, kneel, lie down, etc. d. Other medical reasons (If yes, give reasons.) 20. Have you ever been treated in an Emergency Room? (If yes, for what?) 21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) 22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) 23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) 24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) 25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) 26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) 27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) 28. Have you ever been denied life insurance?
15. HAVE YOU EVER HAD OR DO YOU NOW HAVE: 15.a. Dizziness or fainting spells b. Frequent or severe headache c. A head injury, memory loss or amnesia d. Paralysis e. Seizures, convulsions, epilepsy or fits f. Car, train, sea, or air sickness g. A period of unconsciousness or concussion h. Meningitis, encephalitis, or other neurological problems 16.a. Rheumatic fever b. Prolonged bleeding (as after an injury or tooth extraction, etc.) c. Pain or pressure in the chest d. Palpitation, pounding heart or abnormal heartbeat e. Heart trouble or murmur f. High or low blood pressure 17.a. Nervous trouble of any sort (anxiety or panic attacks) b. Habitual stammering or stuttering c. Loss of memory or amnesia, or neurological symptoms d. Frequent trouble sleeping e. Received counseling of any type f. Depression or excessive worry g. Been evaluated or treated for a mental condition h. Attempted suicide i. Used illegal drugs or abused prescription drugs	19. Have you been refused employment or been unable to hold a job or stay in school because of: a. Sensitivity to chemicals, dust, sunlight, etc. b. Inability to perform certain motions c. Inability to stand, sit, kneel, lie down, etc. d. Other medical reasons (If yes, give reasons.) 20. Have you ever been treated in an Emergency Room? (If yes, for what?) 21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) 22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) 23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) 24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) 25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) 26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) 27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) 28. Have you ever been denied life insurance?				
<p>18. FEMALES ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder b. A change of menstrual pattern c. Any abnormal PAP smears d. First day of last menstrual period (YYYYMMDD) e. Date of last PAP smear (YYYYMMDD)</p>					
<p>29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</p>					
<p>NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."</p>					



NAVMED 1300/4



EXPEDITIONARY MEDICAL and DENTAL SCREENING FOR INDIVIDUAL AUGMENTEE (IA) and SUPPORT ASSIGNMENTS to OVERSEAS CONTINGENCY OPERATIONS (OCO) (This form must be completed in conjunction with DD Form 2807-1, Report of Medical History)			
Service Member Name (Last, First, MI)		Rate / Rank	SSN
Present Station	UIC	Deployment AOR	Anticipated Duties
PART I - RECORD SCREENING (Completed by the Designated Medical Department Representative) Items marked with (●) indicate requirements for CONUS and ADSW Mobilizations. Shaded area responses require explanation in comment sections.			
A. MEDICAL READINESS			
NOTE: Reserve Component (RC) members have TRICARE benefits 90 days before report date of orders			
Date Completed _____			
● 1. Member has medical record in hand.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
● 2 a. Medical Readiness Data entered into Medical Readiness Reporting System (MRRS) and status updated. b. Updated printed MRRS report in medical record.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3. Is member on a Limited Duty Board (AC); pending evaluation by a Physical Evaluation Board (AC); or awaiting Medical Retention Review (RC)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4. Is member in a TNPQ, NPQ, LOD status, pregnant or within 12 months post-partum? Member can request a post-partum waiver per OPNAVINST 6000.1C.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Post-Partum Waiver
● 5. Food/drug allergies documented with medical warning tags on hand.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
● 6. NAVMED 6120/4, Periodic Health Assessment (PHA) completed within 6 months of deployment and updated on DD Form 2766.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
● 7. Report of Medical History (DD Form 2807-1)	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Pre-deployment neurocognitive assessments (example: ANAM) within 12 months of deployment.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Pre-deployment Health Assessment (DD Form 2795) completed within 60 days of deployment, see page 3, Note 4. If service member screened > 50 days, enter "N/A"; member shall return for electronic submission prior to deployment (Note 4A).	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
10. For UN Missions, UN MS. 2 (11-01), Entry Medical Examination completed? AOR Specific.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
● 11. Previously Deployed Personnel meeting DoDI 6490.03 criteria. DD Form 2900 Documented in MRRS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
12. Current Physical Fitness Assessment (PFA) failure?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
● 13. Vital Signs: BP _____ Temp _____ Pulse _____ Respirations _____ Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
B. AUDIOGRAM			
● 1. Audiogram (DD Form 2215 or DD Form 2216 completed within 12 months of deployment).	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Hearing meets minimum standards or member uses a hearing aid and has supply of batteries for duration of deployment. Note: Hearing loss is not a disqualifying factor if corrected to minimum standard by use of a hearing aid.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
C. IMMUNIZATIONS Refer to Part IV, Area of Responsibility (AOR) specific guidelines.			
NOTE: Vaccinations 10 through 15 are live viruses. If two or more live virus vaccinations are needed, and the member is within 28 days of deployment, then all live virus vaccines (including live attenuated and smallpox vaccine) must be administered concurrently or all live virus vaccines should be withheld. Copy of the Individual Medical Readiness (IMR) must be included in the medical record.			
● 1. Hepatitis A Initiated (Basic series of 2 must be complete).	Date (1) _____ Date (2) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
● 2. Hepatitis B Initiated (Basic series of 3, COCOM Specific).	Date (1) _____ Date (2) _____ Date (3) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
● 3. PPD or PPD Converter Questionnaire (annual). COCOM Specific.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Typhoid (Every 2 years for injectable and 5 years for oral).	Date _____ Type _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Anthrax. Basic series of 5 then annual (Received 2 doses prior to deployment). (AOR Specific) (www.anthrax.mil)	<input type="checkbox"/> Start <input type="checkbox"/> 4 Weeks <input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 18 Months	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
● 6. Tetanus-Diphtheria (within 10 years). If due, one-time dose of TDAP in place of Td.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Meningococcal (within 5 years). Only required for deployments to Sudan, Ethiopia, Eritrea, Djibouti, Somalia, and Kenya. (AOR Specific)	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
● 8. IPV (once). Assumed all post accession are immune and do not need immunization.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Service Member Name (Last, First, MI)		Rate / Rank	SSN
PART I - RECORD SCREENING (Continued)			
C. IMMUNIZATIONS (Continued)			
9. Pneumococcal (Give one revaccination 5 or more years after initial vaccination). Only required if asymptotic.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
10. Smallpox or documentation of medical exemption (every 10 years). Include Smallpox Screening Questionnaire as part of DD Form 2766. (AOR Specific)	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
● 11. MMR (once or documented titer). (Assumed all post accession are immune and do not need immunization).	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Yellow Fever (every 10 years). (AOR Specific) Only required for deployments to Sudan, Eritriopia, Entrea, Djibouti, Somalia, and Kenya.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
● 13. Influenza. Injection OR Influenza mist (annual).	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
14. Varicella (Screen for prior disease or titer). (Note: Not given concurrently with smallpox.) a. Service Member has orders to Detainee Operations? If NO, skip to No. 15. b. Documentation of prior disease; prior immunization (2 doses), or Positive titer? c. If 14b is NO: Varicella vaccine given:	Date _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. Japanese Encephalitis vaccine. Only required for deployments to PACOM, WESTPAC, and Okinawa (AOR Specific).	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
● 16. Copy of Individual Medical Readiness (IMR) in medical record.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
D. LABS Results must be in hand before departing Parent Command/NOSC			
● 1. Blood type and Rh factor.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> YES	<input type="checkbox"/> NO
● 2. Stickle trait results.	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> YES	<input type="checkbox"/> NO
● 3. DNA sample collected, registry date recorded.	AFIP Registry Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
● 4. G6PD results with date. If deficient, Red Dog Tags and the statement "NO PRIMAQUINE".	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Red Tags
5. HIV antibody test within 120 days of the projected date of deployment with negative results.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
E. FEMALES ONLY Mark "NA" for males and proceed to "F. Eye Examination"			
PAP SMEARS: Routine gynecological examinations are unavailable in the combat zones of the AOR.			
● 1. Has member had a comprehensive women's health exam within the past year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
● 2. Patients 30 years or older with no history of dysplasia in past and 3 consecutive normal PAP smears and have had a PAP smear within 24 months of deployment. If YES, go to question Part I, ES. If NO, go to questions Part I, E3 and/or E4.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
3. Have normal Pathology report results been documented within 12 months of "boots on ground" in the AOR (NOT the date of arrival at NMPS)? for periods of deployment > 1 year?	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
4. Has member had a hysterectomy for reasons other than cervical dysplasia or cancer and have not had a supra-cervical hysterectomy (PERMANENTLY EXEMPT FROM PAP SMEAR)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
● 5. Females over 50 years: Normal radiological report for mammogram within one year of "boots on ground" in the AOR (NOT date of arrival at NMPS)?	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
6. Counseling and prescription for contraceptives, if desired. (Prescribe enough for duration of deployment plus 30 days). Counselors will emphasize the need to continue contraception during R&R and leave.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
● 7. Documented negative pregnancy results within 30 days of deployment? (Mark N/A for documented hysterectomy.)	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
F. EYE EXAMINATION			
● 1. Member has eye examination within 2 years of deployment.	Date _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Member requires corrective prescription.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
3. If correction required, corrective prescription current (within one year) and on DD Form 771.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
4. If correction required, two sets of glasses with current prescription; to include temple length, bridge size, pupil distance. Required for all OCONUS deployments except EUCCOM.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
5. If correction required, M40 gas mask inserts with current prescription. Required for all OCONUS deployments except EUCCOM.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
6. If correction required, prescription inserts for ballistic inserts. Required for all OCONUS deployments except EUCCOM.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
7. Members best corrected visual acuity meets minimum standards.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
NOTE: Contact lenses are not approved for use by personnel in the CENTCOM AOR unless written authorization is provided by the deploying medical provider and placed in the deployment medical record. Members may wear contact lenses only when authorized by the deployed unit commander. Members deployed with contact lenses must receive pre-deployment education on the safe wear and maintenance of contact lenses in the CENTCOM AOR environment. Members must deploy with 2 pairs of eyeglasses and a supply of contact lens maintenance items adequate for the duration of the deployment.			

Dental Process

*Review
of Dental
Record*

*Dental X-
Rays if
needed*

*Dental
Officer
Visit**

*The dental officer may need to reclassify the member, fill caries, or do wisdom teeth extraction, which may delay the mobilization process



QUESTIONS?

