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Medical

MEDICAL CARE MANAGEMENT

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive AFPD 44-1, Medical Operations, and provides
guidance for the organization and delivery of medical care. It implements various publications of Depart-
ment of Defense (DOD) recognized professional organizations, the Joint Commission on Accreditation of
Healthcare Organizations (JCAHO), and appropriate health and safety agencies. This instruction applies
to all personnel assigned to or working in Air Force Medical Treatment Facilities (MTF) and Aeromedical
Evacuation units, including Reserve and Guard personnel during their active duty periods, civilian, con-
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November 22, 1943. Forms affected by the PA have an appropriate PA statement. Various sys-
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tem; F044 AF PC A, Individual Weight Management File; F044 AF SG C, Dental Health Records; F044
AF SG D, Automated Medical/Dental Record System; F044 AF SG E, Medical Record System; F044 AF
SG J, Air Force Blood Program; F044 AF SG L, Medical Treatment Facility Tumor Registry; F044 AF
SG Q, Family Advocacy Program Record, (k)(2) and (k)(5); F044 AF SG R, Reporting of Medical Con-
ditions of Public Health and Military Significance; F044 AF SG S, Alcohol and Drug Abuse Prevention
and Treatment Program; F044 AF SG T, Suicide Event Surveillance System (SESS); F044 AF SG U, Special
Needs and Educational and Developmental Intervention Services (EDIS); F044 USAFA A, Department of Defense Medical Examination Review Board Medical Examination Files. Submit all
supplements to this Air Force Instruction (AFI) to Air Force Medical Operations Agency/Clinical Quality
Management Division (AFMOA/SGOC) for approval. Send comments and suggested improvements on
AF Form 847, Recommendation for Change of Publication, through channels, to Clinical Quality Man-
agement Division, Air Force Medical Operations Agency; AFMOA/SGOC, 110 Luke Avenue, Suite 405,
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SUMMARY OF REVISIONS

This document is substantially revised and must be completely reviewed. The chapters are reorganized and renumbered to reflect the product lines.

Chapter 1—MANAGING PATIENT TREATMENT AND CLINICAL SERVICES

Section 1A—Areas of Responsibility

1.1. Purpose

1.2. Responsibilities

Section 1B—Organization and Functions

1.3. Overview (Refer to AFI 38-101 also)

Section 1C—Personnel Management

1.4. Name Tags

1.5. Use of the Title of Doctor

1.6. Policy on Rest Standards

1.7. Policy on Off-Duty Employment

1.8. Composite Healthcare System

1.9. MTF Requirements for Tracking Test Results

1.10. MTF Requirements for Ensuring Prompt Response to Patient-initiated Telephone Communications

1.11. Policy on Nurses Faxing Prescriptions

Chapter 2—POLICIES WHICH COVER MULTIPLE PRODUCT LINES

Section 2A—Treatment Documentation

2.1. Treatment Documentation

Section 2B—Informed Consent

2.2. MTF/CC Responsibilities

2.3. Resolving Questionable Issues

2.4. Informed Consent Documentation

2.5. Documentation for Immunizations

Section 2C—Treating Minors

2.6. General Guidelines
Section 2D—Chaperones

2.7. Chaperones ................................................................................................................. 18

Section 2E—JCAHO National Patient Safety Goals

2.8. Will be addressed in a future AFI ............................................................................ 18

Section 2F—Occupational Medicine

2.9. Work Related Illness and Injuries (conditions of public health significance) .......... 18
2.10. Care Of DOD Civilians Injured or Ill in the Line of Duty ........................................ 19

Section 2G—Commercial Insurance Company Physical Examinations

2.11. Completion of Forms ................................................................................................. 19

Section 2H—Medical Core Competencies Obtained During Residency Training

2.12. Overview .................................................................................................................. 19
2.13. Electrocardiogram Interpretation ............................................................................... 19

Chapter 3— PRIMARY CARE PRODUCT LINE

Section 3A—Provision of Care Guidance

3.1. Provision of Care ....................................................................................................... 20
3.2. Technician Clinical Support Protocols. ..................................................................... 20
3.3. Provider-Extender Consultations. .............................................................................. 21

Section 3B—Pseudofolliculitis barbae

3.4. MTF Policy ................................................................................................................ 21

Section 3C—Use of Weight Control Drugs and Surgery

3.5. Use of Weight Control Drugs and Surgery ............................................................ 21

Section 3D—Emergency Services

3.6. Emergency Services .................................................................................................. 21
3.7. Requirements for Basic Life Support (BLS) Training ............................................... 21
3.8. Requirements for Advanced Life Support Training ................................................. 22

Table 3.1. ACLS Requirements by Provider and Area of Work. .............................................. 24
Table 3.2. PALS Requirements by Provider and Area of Work. ........................................... 25
Table 3.3. NRP Requirements by Provider and Area of Work ........................................... 26
3.9. Automated External Defibrillators (AED) and Public Access Defibrillators (PAD) .. 26
3.10. Ambulance Services ................................................................. 27

Chapter 4—MATERNAL-CHILD PRODUCT LINE 28

Section 4A—Preventive Services 28

4.1. Periodic Health Maintenance Examination ........................................... 28
4.2. Mammograms ...................................................................................... 28
4.3. Gynecological Services ........................................................................ 29

Section 4B—Family Planning 29

4.4. Family Planning Services Provided ....................................................... 29
4.5. Sterilization ......................................................................................... 29
4.6. Contraceptive Services ......................................................................... 29
4.7. Induced Abortion .................................................................................. 30

Section 4C—Medical Care Related to Pregnancy 30

4.8. Standards .......................................................................................... 30
4.9. Trial of Labor for Vaginal Birth after Cesarean Section (VBAC) .......... 31
4.10. Epidural Anesthesia for Delivery .......................................................... 31
4.11. Use of Oxytocic Drugs in Pregnancy ..................................................... 32
4.13. Chemical Warfare Defense Ensemble (CWDE) during pregnancy ........... 33
4.14. Assignment Curtailment in Isolated or Remote Areas ......................... 33
4.15. Breastfeeding and Breast Pumping ....................................................... 33
4.16. Weight and Fitness Compliance ............................................................ 34
4.17. Illness During the Prenatal Period ........................................................ 34
4.18. Evaluation of Pregnant Civilian Employees .......................................... 34

Section 4D—Newborn Care 34

4.19. Inborn Diseases .................................................................................. 34
4.20. Newborn and Intensive Care Nurseries ............................................... 35
4.21. Newborn Hospital Stay ....................................................................... 35

Chapter 5—MEDICAL SERVICES PRODUCT LINE 36

Section 5A—Reportable Diseases and Conditions 36

5.1. What and How to Report ................................................................. 36
Chapter 8—CLINICAL LABORATORY AND ANATOMIC PATHOLOGY SERVICES

Section 8A—General Guidance
8.1. General Guidance
8.2. Laboratory Services

Section 8B—Blood Transfusion Services
8.3. Transfusion Services/Blood Donor Centers (BDC)
8.4. Non-FDA Licensed Blood Transfusion Follow-up

Section 8C—Anatomic Pathology Services
8.5. Anatomic Pathology Services

Chapter 9—RADIOLOGY AND RADIOLOGIC SERVICES

Section 9A—Radiology Administration
9.1. Filing Hard Copy Radiographs
9.2. Radiology Technicians
9.3. Early Interpretation:
9.4. Completion of Reports
9.5. Film Loaning and Transfer
9.6. Contract Employees’ X-Ray Films

Chapter 10—PHARMACY SERVICES

Section 10A—Pharmacy Services
10.1. Organization

Section 10B—Policies and Procedures
10.2. Policies and Procedures
10.3. Patient Counseling

Section 10C—Medication Dispensing
10.4. Medication Dispensing

Section 10D—Formulary Management
10.5. Bulk prescriptions
10.6. Use of Formulary Drugs and Non-Formulary Requests
10.7. Air Force High Dollar Drug Program
10.8. Generic Medication ................................................................. 55

Section 10E—Pharmacy and Therapeutics Function 55
10.9. The Pharmacy and Therapeutics Function ........................................ 55

Section 10F—Drug Inventory 55
10.10. Drug Inventory ............................................................................. 55
10.11. Controlled Drug Inventory Process .................................................. 56
10.12. Accountability of Controlled Substances .......................................... 57
10.13. Securing Drugs .............................................................................. 57

Section 10G—Writing Prescriptions 58
10.14. Writing Prescriptions ....................................................................... 58

Section 10H—Packaging Prescriptions 59
10.15. Packaging Prescriptions ................................................................... 60
10.16. Labeling Prescriptions ..................................................................... 60
10.17. Refilling Prescriptions ..................................................................... 60
10.18. Mailing Medications ....................................................................... 61
10.19. Use of Pharmacy Automation Equipment ......................................... 61

Section 10I—Inpatient Pharmacy Services 61
10.20. Inpatient Pharmacy Services .......................................................... 61
10.21. Sterile Product Preparation ............................................................... 61
10.22. Bulk Compounding .......................................................................... 62
10.23. Issuance of Force Health Protection Prescription Products (FHPPP) .......... 62

Chapter 11—OPTOMETRY SERVICES 63
11.1. Policies and Procedures .................................................................... 63
11.2. Contact Lens Services ....................................................................... 63
11.3. Documentation of Optometry Services. .............................................. 63

Chapter 12—PHYSICAL/OCCUPATIONAL THERAPY SERVICES 64
12.1. Requests for Occupational and/or Physical Therapy ............................. 64
12.2. Documentation .................................................................................. 64
Chapter 13—BEHAVIORAL HEALTH SERVICES 65

Section 13A—Continuity of Care and Other Issues for Mental Health Patients 65

13.1. Initial Evaluations ...................................................................................................... 65
13.2. Follow-up by the Life Skills Support Center ............................................................. 65
13.3. Evacuation and Hospitalization. ................................................................................ 65
13.4. The Repatriate Program of Assistance to Mentally Ill US Citizens/Nationals
      Returned from Foreign Countries. ............................................................................. 66

Section 13B—Using Clinical Hypnosis 66

13.5. Provider Privileges ..................................................................................................... 66

Section 13C—Formal Sex Therapy 66

13.6. Clinician Requirements: ............................................................................................ 66

Chapter 14—ALLERGY AND IMMUNIZATIONS SERVICES 67

14.1. Responsibilities: ......................................................................................................... 67
14.2. Training for Allergy Immunotherapy (AIT) Personnel ............................................. 68
14.3. Quality Assurance: ..................................................................................................... 69
14.4. Allergy Clinic and AIT Administrative Issues .......................................................... 70

Chapter 15—AUDIOLOGY SERVICES 71

15.1. Diagnostic Hearing Centers (DHC) ........................................................................... 71
15.2. Accessories, Spare Parts, Batteries ............................................................................ 71
15.3. Repair of Defective Hearing Aids ............................................................................. 72
15.4. Return of Unserviceable Hearing Aids ...................................................................... 72
15.5. Replacement Hearing Aids ........................................................................................ 72
15.6. Accountability for Hearing Aids ................................................................................ 72

Chapter 16—ALTERNATIVE MEDICINE SERVICES 73

Section 16A—Chiropractic Care 73

16.1. General Guidelines .................................................................................................... 73
16.2. Scope of Chiropractic Services. ................................................................................ 73

Section 16B—Acupuncture 73

16.3. Clinician Requirements: ............................................................................................ 73

Section 16C—Internet Pharmacies 73
16.4. Active duty members are prohibited from obtaining medications .................................. 73

Chapter 17—MEDICOLEGAL MATTERS .................................................................................. 74
17.1. Medical Law Consultants (MLC) .................................................................................. 74
17.2. Healthcare Provider and Patient Privileged Communications .................................. 74
17.3. Biological Specimens in Administrative or Judicial Proceedings ............................ 74
17.4. Reporting Serious Incidents ......................................................................................... 75

Chapter 18—FORMS PRESCRIBED ....................................................................................... 76
18.1. IMT Forms Prescribed: ............................................................................................... 76
18.2. Personal Identification ............................................................................................... 76
18.3. IMT Forms Adopted ................................................................................................. 77

Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION ............ 79
Chapter 1

MANAGING PATIENT TREATMENT AND CLINICAL SERVICES

Section 1A—Areas of Responsibility

1.1. Purpose. This chapter provides guidance for the general delivery of patient care and management of clinical services throughout the Air Force Medical Service (AFMS).

1.2. Responsibilities.

1.2.1. The Air Force Surgeon General (SG):
   1.2.1.1. Monitors implementation of this instruction throughout the Air Force.

1.2.2. Major Command Surgeons (MAJCOM/SG or equivalent):
   1.2.2.1. Ensures commands implement these instructions and recommends any additions, deletions or amendments.

1.2.3. Medical Treatment Facility Commanders (MTF/CC):
   1.2.3.1. Complies with this instruction and ensures personnel under their authority observe them.
   1.2.3.2. Where the MTF comprises a Medical Wing, the MTF/CC may delegate responsibilities outlined in this instruction to the Vice Wing or MDG/CC as appropriate.

Section 1B—Organization and Functions

1.3. Overview (Refer to AFI 38-101 also)

1.3.1. The MTF Organizational Plan. MTFs will be organized in accordance with (IAW) the Objective Medical Group (OMG) in AFI 38-101, Air Force Organization, and includes the office of the Chief, Medical Staff, the Chief Nurse Executive; and clinical services necessary to perform the wing/installation medical services mission. Commanders and supervisors in the chain of command subordinate to the MTF Commander control conditions of employment including place, time and means of work. Commanders exercise command prerogatives over military members. Standards for competent clinical performance and professional conduct of privileged providers are matters for professional clinical peer review as outlined in AFI 44-119, Clinical Performance Improvement. The MTF Commander has ultimate responsibility for, and authority over professional standards and clinical performance.

1.3.2. Chief, Medical Staff (SGH)

1.3.2.1. Is a Medical Corps officer, or civilian physician, who maintains regular privileges in their specialty, reports directly to the MTF/CC and is an active medical staff member.

1.3.2.2. Is responsible to MTF/CC for the conduct of professional clinical peer review functions that define clinical standards of care (AFI 44-119), and advises the MTF/CC about actions required in relation to the clinical performance and professional conduct of privileged providers.

1.3.2.3. May appoint an Assistant Chief of the Medical Staff, who may be a privileged provider of any corps in the AFMS.
1.3.3. Chief, Aerospace Medicine (SGP)

1.3.3.1. The SGP will be the most qualified flight surgeon. Depending upon rank and capability, this will be an Aerospace Medicine Specialist (Air Force Specialty Code AFSC 48AX) whenever one is assigned; or, when no 48AX is assigned, the SGP will typically be the senior flight surgeon, (AFSC 48XX).

1.3.3.2. Is responsible to the MTF/CC for the clinical aspects of all aerospace medicine activities.

1.3.4. Chief Nurse Executive

1.3.4.1. Each MTF will have a qualified Nurse Corps officer designated as the Chief Nurse Executive.

1.3.4.2. The Chief Nurse Executive has primary oversight of the clinical nursing activities of non-privileged providers throughout the organization, and will collaborate with other clinical disciplines in the development of the organizational plan for the delivery of nursing care.

1.3.4.3. The Chief Nurse Executive ensures that all nursing personnel are competent to perform their assigned responsibilities, IAW AFI 46-101, Nursing Services and Operations and advises the MTF/CC about actions required in relation to the clinical performance and professional conduct of non-privileged practitioners.

1.3.5. Chief, Dental Services (SGD)

1.3.5.1. The SGD will be the most qualified dental officer and will typically be the senior dental officer.

1.3.5.2. Is responsible to the MTF/CC for the clinical and administrative aspects of all dental activities

1.3.6. Privileged Providers

1.3.6.1. Privileged healthcare providers assume complete responsibility for evaluating their patients’ medical and dental problems and for prescribing an individualized therapeutic program within the scope of their clinical privileges.

1.3.6.2. The responsibility for the care of each admitted in-patient must be assigned to a provider fully privileged for the scope of care appropriate to the inpatient unit.”

1.3.6.3. It is the responsibility of the provider to maintain contact with the MTF personnel while on-call. Providers shall not rely on the exclusive use of a “pager,” “beeper,” or cellular telephone, and must ensure they can be contacted by MTF personnel in a timely manner.

1.3.6.4. A provider will see and evaluate his/her designated inpatients at least once each day, and document the visit. Patients on holding or self-care units need not see a provider every day, unless new symptoms develop.

1.3.6.5. An attending physician, oral surgeon or dentist with Intensive Care Unit (ICU) privileges will evaluate their patients in the Coronary Care Unit (CCU), ICU, and in the Special Care Unit (SCU) at least twice each day, and document each visit.
Section 1C—Personnel Management

1.4. Name Tags

1.4.1. Name tags worn on the Air Force uniform by members of the AFMS must conform to current policies regarding Air Force uniforms. NOTE: Optional nametags on hospital work clothing must provide adequate identification of medical personnel.

1.4.1.1. Use the following designations as described:

1.4.1.1.1. “Dr.” and the last name, for physicians, dentists, and providers possessing doctorate level degrees.

1.4.1.1.2. Grade and last name of individual on the top line and specialty on the bottom line for officers whose grade insignia does not show on work clothing.

1.4.1.1.3. Last name of the individual on the top line and specialty on the bottom line for officers whose grade insignia shows on work clothing. If enlisted personnel must wear such name tags, they are furnished to them without cost to the individual. NOTE: Personnel may not wear name tags authorized for optional wear on service or utility uniforms.

1.5. Use of the Title of Doctor. Address medical service personnel with doctoral degrees as "Doctor" in connection with the performance of their duties. NOTE: In official communications, address officers of the AFMS by their military rank.

1.6. Policy on Rest Standards

1.6.1. Each MTF must have written policy on rest standards based on mission requirements, stating:

1.6.1.1. The minimum number of hours of uninterrupted rest between shifts of providing direct patient care.

1.6.1.2. The maximum number of consecutive hours of direct patient care allowed.

1.6.1.3. Time “on call”, either at home or in-house, is not considered “direct patient care”.

1.6.1.4. The waiver process when those standards must be broken for unusual circumstances.

1.6.2. MTFs with Graduate Medical Education (GME) programs will abide by the Accreditation Council for Graduate Medical Education (ACGME) Standards for duty time and rest standards. http:/ /www.acgme.org/

1.7. Policy on Off-Duty Employment (Refer to AFI 44-119 concerning Adverse Actions and Off-Duty Employment)

1.7.1. Affected Personnel:

1.7.1.1. Medical Corps, Dental Corps, Nurse Corps, Biomedical Science Corps and Medical Service Corps, enlisted technicians, and civilian who would be members of these corps if they were in a commissioned status. Applicability to contract personnel depends upon the wording of the contract.

1.7.1.2. Civilian equivalents only need to comply with provisions of the Joint Ethics Regulation concerning off-duty employment. The MTF/CC may establish additional procedures if the local
situation warrants such action. **NOTE:** Off-duty employment refers to all forms of off-duty employment; it is not confined to medically related areas.

1.7.2. Requirements

1.7.2.1. All physicians must attend a briefing by the Chief of the Medical Staff upon arrival to each new duty station, and then annually, on the provisions and restrictions of off-duty employment. Senior Corps representative will provide the brief to members of other corps. Commanders for officers or civilians permanently assigned to another organization but regularly performing duties within an MTF will have a written agreement with the MTF/CC on methods of fulfilling the requirements.

1.7.2.2. Internal review procedures will be in place to monitor providers’ compliance with off-duty employment provisions at least annually.

1.7.3. Types of services that can be provided as off-duty employment:

1.7.3.1. The Air Force encourages healthcare providers to teach, write and publish.

1.7.3.2. Providers may serve other than DOD beneficiaries only when there is documented community or emergency need. The local professional society must provide a written statement documenting this need. This document will be filed with other documentation pertaining to a provider’s off-duty employment.

1.7.4. Restrictions for Off-Duty Employment

1.7.4.1. All personnel on active duty must first obtain the written permission of the MTF/CC, through the Squadron/CC, after coordination with the Chief of the Medical Staff, Chief Nurse Executive, Senior Corps Chief or Career Functional Manager and through the Wing or Group Legal Advisor. MAJCOM and Air Staff personnel require permission from the MAJCOM Surgeon, United States Air Force Surgeon General (USAF/SG) or their designee; respectively, other non-MTF providers require permission from the most senior medical officer in their chain of command.

1.7.4.2. Squadron Commanders or higher authority may withdraw permission for personnel to engage in off-duty employment at any time.

1.7.4.3. Off-duty employment shall not exceed 16 hours per week. This limitation does not apply to off-duty employment performed while on official leave status. **EXCEPTION:** The MTF/CC may approve periods that exceed 16 hours per week.

1.7.4.4. A period of at least six hours of rest must elapse between the end of the off-duty employment and the start of the duty period.

1.7.4.5. Military personnel may only work at a site that is close enough to allow the individual to return promptly if military duty requires return.

1.7.4.6. For off-duty employment during non-duty hours of normal duty days, providers must be able to return to the MTF within two hours by land. Personnel may not travel by air beyond acceptable land travel distances for travel time. For off-duty employment during non-duty days or on official leave, personnel are not restricted by the two-hour return time to the MTF.

1.7.4.7. Military healthcare personnel who are students in graduate medical education training programs may not engage in off-duty employment.
1.7.4.8. Military healthcare providers engaged in off-duty employment may not assume primary responsibility for the care of any patient on a continuing basis at the off-duty site. **EXCEPTION:** This does not apply to personnel on terminal leave.

1.7.4.9. Military healthcare providers may not provide off-duty healthcare services:

1.7.4.9.1. On military premises.

1.7.4.9.2. Involving expense to the federal government.

1.7.4.9.3. Using military equipment, personnel or supplies.

1.7.4.10. DOD healthcare providers may not solicit or accept compensation, directly or indirectly, for care rendered to any DOD beneficiary entitled to medical or dental care. **EXCEPTION:** Active duty military dentists “moonlighting” in the civilian sector may provide care to individuals enrolled in the TRICARE Family Member Dental Plan, IAW Health Affairs Policy #97-019, *Off-Duty Employment by DOD Dental Care Providers.*

1.7.4.11. A DOD healthcare provider may not refer a patient from an MTF to a facility in which the provider maintains off-duty employment. If such referral is unavoidable, the provider must document the reason in a letter to the MTF/CC.

1.7.4.12. Off-duty employers must certify that they accept the compensation and availability limitations placed on DOD healthcare providers and agree that as a condition of off-duty employment, they will not seek reimbursement from TRICARE or directly from the patient for services provided a DOD beneficiary.

1.7.4.13. Individual healthcare providers on off-duty employment must comply with local licensing requirements, Drug Enforcement Agency (DEA) requirements and provide their own personal liability coverage. The Air Force is not responsible for the actions of individuals working in off-duty employment.

1.7.4.14. DOD healthcare providers will apply for annual leave for any off-duty employment obligations that require absence during duty hours.

1.7.4.15. Each military member approved for off-duty employment must:

1.7.4.15.1. Update the status of off-duty employment within one week of any change in status.

1.7.4.15.2. Submit a monthly summary to the MTF/CC stating the places, dates and hours of off-duty employment performed. **EXCEPTION:** Personnel on terminal leave need not submit monthly summaries.

1.7.4.16. DOD and military healthcare personnel off-duty employment must not interfere with, or unfairly compete with, local civilian providers in the health professions. **EXCEPTION:** Personnel on terminal leave may compete for employment with local civilian providers.

1.8. **Composite Healthcare System (CHCS) Documentation Issues**

1.8.1. Reviewing laboratory, radiologic reports and CHCS email.

1.8.1.1. Every provider must review pending laboratory, radiologic reports and CHCS email in a timely manner, but no less than weekly.

1.8.2. Surrogates
1.8.2.1. If a provider will be unavailable, due to leave, temporary duty (TDY), deployments, Permanent Change of Station (PCS), separation or for any prolonged period of time, i.e. greater than one week, they must assign a surrogate in CHCS to review and act on laboratory tests or radiologic studies reported during their absence.

1.8.3. Information Management Sign-out

1.8.3.1. When a provider is leaving a facility, during a PCS or separation, they must sign all outstanding orders in CHCS before leaving.

1.9. MTF Requirements for Tracking Test Results: MTFs, with SGH oversight, must:

1.9.1. Implement procedures for tracking diagnostic test results (laboratory and radiology) to ensure timely review by providers, timely notification of the patient and documentation of any medically indicated actions taken in the medical record.

1.9.2. Define critical value thresholds and outline the notification process of critical results including standards for the timely completion of each phase of the process, depending on the test involved and the ordering clinical area.

1.9.3. Assign responsibility for monitoring designated functions.

1.9.4. Develop and promulgate provider and patient responsibilities, i.e. providing a way, telephone or address to contact them with results.

1.9.5. Implement procedures for locating patients and notifying them of their test results.

1.10. MTF Requirements for Ensuring Prompt Response to Patient-initiated Telephone Communications: MTFs, with SGH oversight, must:

1.10.1. Develop procedures to ensure patient-initiated telephone communications to providers are answered promptly and documented in the medical record.

1.10.1.1. The procedures must define standards for timely response based on whether the issue to be addressed is acute, routine, or involves wellness issues.

1.10.1.2. The procedures must assign responsibility for monitoring this process.

1.11. Policy on Nurses Faxing Prescriptions

1.11.1. In the event that a patient is unable to pick-up a written paper copy of a prescription, and both the provider and the pharmacy concur with the practice, a member of the staff may fax the document to the pharmacy. This guidance applies to nursing personnel in all MTFs within the AFMS. Faxing of information will be performed IAW Public Law 104-191, Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security guidelines.
Chapter 2

POLICIES WHICH COVER MULTIPLE PRODUCT LINES

Section 2A—Treatment Documentation

2.1. Treatment Documentation: Every outpatient evaluation and treatment episode, (including anesthesia; behavioral or Life Skills therapy, patient education, alternative medicine such as acupuncture and chiropractic; ancillary care such as physical or occupational therapy, nutritional medicine) will be documented and entered into the Outpatient Health Record, Dental Health Record or in an electronic health record in use in the Military Healthcare System. Radiology and laboratory episodes of care will be documented through the generation of reports and results, which must be included in the Outpatient record. In the event that the Outpatient Health Record is unavailable, the episode will be annotated and sent to the records room for inclusion into the Outpatient Health Record.

Section 2B—Informed Consent

2.2. MTF/CC Responsibilities: The MTF/CC or designee at each MTF establishes specific guidance on informed consent, consistent with any relevant state law and reasonable standards of medical practice. Although local policy need not list all procedures or itemize what disclosures must be made in specific types of cases, it must provide a method for providers in the MTF to obtain answers to specific informed consent questions such as extent of disclosures or whether to use written consent forms.

2.3. Resolving Questionable Issues

2.3.1. Providers shall consult the Staff Judge Advocate (SJA) and the regional Medical Legal Consultant (MLC) to determine any peculiar standards concerning informed consent.

2.3.2. Providers shall obtain information concerning consent and disclosure practices from local medical institutions, state and national professional organizations, and from the MLC annual briefing.

2.3.3. The treating provider, (or resident with the oversight of the attending physician) is ultimately responsible for assuring that informed consent is obtained and documented.

2.4. Informed Consent Documentation

2.4.1. Verbal consent is not acceptable unless in extreme circumstances.

2.4.2. Consent needs to be obtained and recorded prior to sedation or procedure requiring consent and before premedication is given.

2.4.3. The attending provider documents informed consent on SF Form 522, Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (or other locally required form), on AF Form 1225, Informed Consent for Blood Transfusion, or on the SF 600, Health Record Chronological Record of Medical Care. When SF Form 522 or AF Form 1225 are used, there must also be a handwritten entry or overprint in the medical record. Minimum requirements for the documentation include:

2.4.3.1. The nature of the proposed care, treatment, services, medications, interventions, or procedures.
2.4.3.2. Potential benefits, risks, or side effects, including potential problems related to recovery,
2.4.3.3. The likelihood of achieving care, treatment, and service goals,
2.4.3.4. Reasonable alternatives to the proposed care, treatment, and service,
2.4.3.5. The relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services.
2.4.3.6. When indicated, any limitations on the confidentiality of information learned from or about the patient.

2.4.4. Dental informed consent will conform to AFI 47-101, *Managing Air Force Dental Services*.

2.5. Documentation for Immunizations

2.5.1. Immunizations will be documented in the Air Force Complete Immunizations Tracking Application (AFCITA) program. Individuals entering data into AFCITA must complete the AFCITA training. Documentation will be IAW AFJI 48-110 *Immunization and Chemoprophylaxis*.

*Section 2C—Treating Minors*

2.6. General Guidelines:

2.6.1. In all instances where MTFs provide care to minors without parental consent, personnel must make every effort to encourage the patient to inform parents of their medical issues. In most instances, parents can have access to a minor child’s medical record, thus the minor shall be made aware that any care they receive may be discovered. For specific questions, regarding confidentiality for minors, contact the SJA at the local base for advice.

2.6.2. Treating Minors in Continental United States (CONUS): MTF/CC must comply with local state laws governing consent for medical treatment of minors to the extent that those laws are in compliance with applicable federal guidelines and/or case law. For a specific definition of “minor” contact the SJA at the local base for advice.

2.6.3. Treating Minors Overseas: Outside the US, the MTF/CC must work within the general principles of American law in treating minors, in cooperation with the local Judge Advocate office and provide care without parental consent. The following list does not reflect “general principles of American law,” but rather laws specific to a number of states. Recommend SJA review.

2.6.3.1. Reproductive counseling and care for pregnancy and pregnancy-related conditions.
2.6.3.2. Counseling for drug, alcohol and tobacco abuse.
2.6.3.3. Counseling and treatment for sexually transmitted diseases and medical conditions where there is an imminent threat to life or limb.
2.6.3.4. Contraceptive counseling and treatment.
2.6.3.5. Counseling and treatment following rape.
Section 2D—Chaperones

2.7. Chaperones

2.7.1. Each MTF shall develop local procedures regarding the use of chaperones, for the protection of both patients and providers. At a minimum, these local procedures must contain:

2.7.1.1. Assurance of privacy for examination and treatment.
2.7.1.2. Strict privacy considerations for robing and disrobing.
2.7.1.3. Circumstances for presence of a third party at request of the patient or provider.
2.7.1.4. Circumstances for presence of a third party during the exposure, examination or treatment of patient’s genitalia, rectum or female breasts, and during hypnosis, if performed in the MTF.
2.7.1.5. Communication to the patient of the nature and purpose of the examination or treatment and the extent and purpose of disrobing.
2.7.1.6. Education and training requirements for providers and staff on the role of third parties, procedures for identifying and reporting suspected misconduct and procedures for resolving questions of the use of third parties.
2.7.1.7. EXCEPTION: During emergencies or life-threatening situations, medical personnel are not required to offer the presence of a third party.

2.7.2. Each MTF must ensure the chaperone policy is made known and available to all patients.

Section 2E—JCAHO National Patient Safety Goals

2.8. Will be addressed in a future AFI

Section 2F—Occupational Medicine

2.9. Work Related Illness and Injuries (conditions of public health significance)

2.9.1. Effective prevention of work related illnesses and injuries begins with all medical providers developing a working knowledge of the major occupational activities taking place at their assigned installation(s). All inprocessing healthcare providers must receive a briefing on the major industrial activities at their base. This will be organized through the SGP. Particular discussion shall focus on how medical illnesses and injuries can arise from these activities and how medical providers can play a role in identifying and preventing these occurrences. Work places, which have experienced occupational illnesses or injuries, shall receive special focus. The installation occupational health program is detailed in AFI 48-145, Occupational Health Program. This AFI discusses the role of Bioenvironmental Engineering, Public Health and Flight Medicine in assisting MTF providers through the Occupational Health Working Group, how to evaluate, quantify risk and manage work related injury and illness.

2.9.2. Healthcare providers must identify and report all suspected or confirmed occupationally related injuries to the Wing Ground Safety office and illnesses to Public Health. Healthcare providers shall also consult with the SGP in order to affect appropriate preventive measures. In other than emergency
situations, the eligibility for care regulations applies for follow-up medical care and MTF’s should not assume the entire care for an injury.

2.9.3. Personal Protection Equipment (PPE) and Universal Precautions will be followed by every person, military, civilian or contractor as determined by the Infection Control Committee and Bioenvironmental Engineering. Meticulous infection control practices are routinely used to protect healthcare workers and staff to include the appropriate use of PPE when treating patients. Additionally, any examination which involves examination of the genitalia or rectum will require the provider to wear gloves, at a minimum.

2.9.4. Suspected clinically acquired infections among healthcare workers should be reported to Infection Control Officer/Management Team.

2.10. Care Of DOD Civilians Injured or Ill in the Line of Duty

2.10.1. Eligible DOD employees who become ill or who are injured in the line of duty may choose to obtain care from the military health system or from their private healthcare provider, IAW AFI 41-114, Military Health Services System (MHSS) Matrix.

Section 2G—Commercial Insurance Company Physical Examinations

2.11. Completion of Forms

2.11.1. Privileged providers may complete commercial insurance company physical examination forms for Air Force beneficiaries. Insurance companies cannot be billed for this service, IAW AFI 41-114, and AFI 41-115, Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS). AFH 41-114 and AFI 41-115 are being combined into AFI 41-210 TRICARE Operations and Patient Administration Functions.

Section 2H—Medical Core Competencies Obtained During Residency Training

2.12. Overview

2.12.1. Core competencies are developed during residency training and these are to be evaluated during the credentialing and privileging process.

2.13. Electrocardiogram Interpretation

2.13.1. Any provider whose residency includes electrocardiograph interpretation as a core competency may apply for privileges to interpret electrocardiogram. Electrocardiograms need not be sent to Cardiology or Internal Medicine for over-read if a privileged provider annotates an interpretation and signature on the electrocardiogram.
Chapter 3

PRIMARY CARE PRODUCT LINE

Section 3A—Provision of Care Guidance

3.1. Provision of Care

3.1.1. Primary care, pediatrics, internal medicine and aerospace medicine clinics will abide by the concept of providing a Primary Care Manager (PCM) for patients to provide continuity of general preventive, diagnostic and therapeutic care for patients.


3.1.3. Emergency Services Availability. When an MTF is unable to staff an emergency department 24 hours a day, the MTF must publicize alternate sources of care. Acute or urgent care centers do not qualify as emergency departments.

3.1.4. The MTF/CC may organize any specialized medical or surgical service as a separate organizational element within the wing, group and squadron structures described in the most current OMG guidance.

3.2. Technician Clinical Support Protocols. AFMS clinical protocols optimize the utilization of support staff to function at the maximum level of practice.

3.2.1. All 4NX0 technician protocols will be reviewed by the Chief Nurse Executive prior to implementation to ensure scope of practice variations are approved IAW AFI 46-101. The review will be coordinated with the SGH and the senior 4N Career Functional Manager. The review must occur at all levels initially and annually.

3.2.2. Technician clinical decision support protocols may be utilized when the following three criteria are met:

3.2.2.1. The extended scope of the task or procedure is mission essential, i.e. Independent Duty Medical Technicians (IDMTs).

3.2.2.2. The technician staff utilizing the protocols must be trained for the expanded scope of care by a competent trainer, and that training must be documented in the 6-part Education and Training folder.

3.2.2.3. The expanded role of the medical technician must be restricted to practice within the confines of the DOD Healthcare System, i.e. IDMTs may provide treatment only to active duty members.

3.2.3. When clinical decision support protocol use outside the usual technician scope of practice, as outlined in the Career Field Education and Training Plan (CFETP) is appropriate for a facility, the MTF must submit a request to the MAJCOM/SG for waiver IAW AFI 44-119. Waiver requests must be resubmitted annually for revalidation/approval.
3.2.4. IDMT’s will follow established procedures IAW AFI 44-103, *The Air Force Independent Duty Medical Technician Program and Medical Support for Mobile Medical Units/Remote Sites*.

3.3. **Provider-Extender Consultations.** When provider extenders (nurse providers or physician assistants) are seeing a patient for the third time for the same acute medical problem a physician-preceptor will be consulted about the case. This requirement does not include chronic stable diagnoses, which may be seen IAW any supervision plan for the extender that may be in place.

**Section 3B—Pseudofolliculitis barbae**

3.4. **MTF Policy** : MTFs will develop written policies and procedures for managing personnel with pseudofolliculitis barbae. Allowable length of facial hair, during active inflammation will be no longer than one-quarter inch as approved by the installation commander.

**Section 3C—Use of Weight Control Drugs and Surgery**

3.5. **Use of Weight Control Drugs and Surgery**

3.5.1. Weight control medication is not approved for routine use in overweight active duty members and will not be a standard part of the MTF formulary.

3.5.2. Short term use of weight control medication may be considered in carefully selected obese patients with a Body Mass Index (BMI) of 30 kg/m² or greater, or in those with a BMI equal to or greater than 27 with significant comorbid risk factors (such as hypertension, dyslipidemia or insulin resistance syndrome). Drug therapy shall be used in conjunction with behavioral modification, monthly provider follow-up, dietary counseling, and appropriate aerobic exercise. At a minimum, these individuals require history and physical examination, fasting blood glucose, thyroid function studies and evaluation for secondary causes of obesity, as well as complete blood count, lipid profile and a 24-hour urine collection for urine free-cortisol where indicated.

3.5.3. Use of appetite suppressants or lipase inhibitor drugs must be IAW 48-123 when considering profile, deployment or flying status. If used, a profile is required prohibiting deployment for the duration of the short-term supervised therapy.

3.5.4. Active duty members are not authorized to obtain weight reduction (bariatric) surgical procedures.

**Section 3D—Emergency Services**

3.6. **Emergency Services**

3.6.1. Each MTF must have a written plan describing how medical emergencies will be handled for patients in the locality of the MTF.

3.6.2. Provisions for, and care rendered, will be in compliance with relevant Health Services Inspection (HSI) guidance, JCAHO guidelines and Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA) legislation.

3.7. **Requirements for Basic Life Support (BLS) Training**
3.7.1. Each MTF/CC will designate, in writing, an Emergency Resuscitation training coordinator.

3.7.1.1. The training coordinator will track the currency of BLS of assigned members and those in-processing to the MTF.

3.7.1.2. The MTF/CC designates the training coordinator to coordinate BLS provider/instructor training for DOD affiliated area organizations that are otherwise unable to obtain this training. Organizations requesting this training will provide funding.

3.7.2. Personnel may register and train under the auspices of the American Heart Association (AHA), the American Red Cross (ARC), or through an equivalent course by an accredited organization.

3.7.3. Requirements for personnel (including civilians and contractors) involved in direct patient care:

3.7.3.1. Personnel must maintain current registration in a basic provider CPR (Cardio-Pulmonary Resuscitation) course: AHA BLS Course C, ARC CPR/BLS Course, or an equivalent course by an accredited organization. Personnel with demonstrated proficiency may receive a local waiver of CPR/BLS at the discretion of the MTF/CC.

3.7.4. Requirements for medical personnel (including civilians and contractors) who are not involved in patient care, but are working in-patient care areas:

3.7.4.1. All personnel must maintain current registration in either the AHA BLS Course A, ARC Adult CPR Course (Race for Life), or an equivalent course by an accredited organization.

3.7.5. Requirements for non-medical personnel (including civilians and contractors) who are not involved in direct patient care, and who do not work in patient care areas:

3.7.5.1. The local MTF/CC will determine the CPR/BLS requirement for these personnel.

3.8. Requirements for Advanced Life Support Training

3.8.1. General Requirements for Advanced Life Support training (Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Neonatal Resuscitation Program (NRP), or equivalent courses by an accredited program) are as noted in Table 3.1.-Table 3.3. NOTE: The term “certification” refers to the successful demonstration of the written and cognitive skills, either in a standard ACLS/PALS/NRP course, or the equivalent course provided by an accredited organization. The term “training” refers to participation in a standard ACLS/PALS/NRP course or the equivalent. Although successful completion is expected, certification is not critical to the fulfillment of this requirement or training. (See tables). All providers and combat medics can be expected to deploy at any time and they will be current in ACLS training.

3.8.1.1. Every six months, the MTF credentials function will review the records of providers (military, civilian and contract), who have not received the requisite level of certification. In such cases, appropriate privileging action may be required IAW AFI 44-119.

3.8.2. Exemptions, Waivers and Extensions: In some instances, the MTF/CC may provide exemptions or waivers from the requirements for advanced life support (ACLS/PALS/NRP) certification and training.

3.8.2.1. Exemptions: Individuals with sufficient critical care experience in managing cardiopulmonary arrest situations independently may request a letter of exemption from certification from
MTF/CC. This exemption must be reviewed by the credentials function and reaccomplished every two years. Documentation pertaining to the nature and extent of each review will be maintained in the appropriate provider credentials file.

3.8.2.2. Waivers: In select situations, the MTF/CC may waive the requirement for periodic advanced life support training. Such situations may apply to civilian contractors who work limited hours; in settings where there is adequate emergency back-up and advanced life support capabilities are readily available. This waiver authority shall be used sparingly, and not based on a person’s inability to pass the certification.

3.8.2.3. Extensions: In situations where a provider’s ACLS or PALS certification expires when the provider is not able to accomplish recertification, the MDG/CC may grant an extension for up to 3 months, which must be reviewed by the credentials function. The BLS and NRP certifications and training may not be extended.

3.8.3. Specific advanced life support training requirements:

3.8.3.1. ACLS certification is required by any healthcare provider (physician, resident physician, dentist, resident dentist, physician assistant, podiatrist, nurse practitioners and anesthetists, midwife or clinical nurse) who works in acute medical care (primary care clinics), labor and delivery units, with intravenous contrast media, moderate sedation, or general anesthesia caring for adults (18 years and older), regardless of the clinical area where the care is provided, except when exempted under conditions of paragraph 3.8.2.1. Dentists who provide sedation or general anesthesia must be ACLS certified. The use of nitrous oxide alone or with local anesthetic does not require ACLS certification. Dentists who only provide Dental Officer on-call coverage and do not provide sedation do not need to be ACLS certified.

3.8.3.1.1. ACLS certification is required for clinical nurses who work in intensive care settings, labor and delivery emergency department, and in the recovery room.

3.8.3.1.2. ACLS is required for all providers expected to provide combat medical care in a deployed location, i.e. everyone assigned to a UTC.

3.8.3.1.3. ACLS training is highly desirable for medical technicians who work in a labor and delivery setting, intensive care settings, the emergency department, and in the recovery room.
Table 3.1. ACLS Requirements by Provider and Area of Work.

<table>
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<tr>
<th>Provider#</th>
<th>ICU</th>
<th>SCU</th>
<th>CCU*</th>
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#Provider: Physician (MD or DO)--regardless of specialty; PA (Physician Assistant); NP (Nurse Provider)--adult care nurse provider; Dentist; Podiatrist; CRNA (Certified Registered Nurse Anesthetist); Midwife (nurse midwife); Nurse (clinical nurse); IDMT (Independent Duty Medical Technician)--although encouraged, advanced life support training of technicians does not equate to the granting of privileges to manage a cardiac emergency.

*Practice Setting/Services Provided: ICU, SCU, CCU (Intensive Care Unit, Special Care Unit, Cardiac Care Unit)--intensive care services; OR (Operating Suite)--operating services and anesthesia; ED (Emergency Department)--emergency services, including ambulance transport but not including dentists evaluating acute dental problems; hem sedation is not required; OB, L&D (Obstetrical Unit)--obstetrics services; RR (Recovery Room)--recovery room services; Gen Anes (General Anesthesia)--anesthesia services; Mod Sed (Moderate Sedation)--moderate sedation services--wherever they are provided; Adult PCC (Adult Primary Care Clinic)--adult acute care and primary care settings; Radiology--radiology services; Mobility--(assigned to a Unit Type Code in a mobility position).

C--“Certification” requires successful completion of a standard ACLS course or the equivalent. It is a biennial requirement.

T--“Training” refers to participation in a standard ACLS course or the equivalent; although successful completion of the course is expected, it is not critical to the fulfillment of this requirement. It is a biennial requirement.

N/A--not applicable where the practice setting/services provided are not generally considered within the range of care of the particular provider.

3.8.3.2. PALS certification is required by any privileged healthcare provider (physician, resident physician, dentist, resident dentist, physician assistant, nurse provider, anesthetist) who delivers acute medical care (primary care but not general dental clinic), intravenous contrast media, moderate sedation, or general anesthesia to infants, children, and/or adolescents (before the 18th birthday) regardless of the clinical area where the care is provided, except when exempted under
conditions of paragraph 3.8.2.1. EXCEPTION: Dentists providing acute care in emergency room or in Dental Clinic with or without sedation provided by a CRNA, oral surgeon, or Anesthesiologist does not need to be certified in PALS.

3.8.3.2.1. PALS certification is mandatory for nurses who work in the emergency department, operating suites (including ambulatory surgery units), and in intensive care settings where children are admitted. PALS training is highly desirable for medical technicians working in these areas.

3.8.3.2.2. PALS training is highly desirable for nurses and medical technicians who work in pediatric acute care clinic or an inpatient ward where pediatric patients are admitted.

### Table 3.2. PALS Requirements by Provider and Area of Work.

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#Provider: Physician (MD or DO)--regardless of specialty; PA (Physician Assistant); NP (Nurse Provider)--pediatric care nurse provider; Dentist; Podiatrist; CRNA (Certified Registered Nurse Anesthetist); Nurse (clinical nurse); Technician--although encouraged, advanced life support training of technicians does not equate to the granting of privileges to manage a cardiac emergency.

*Practice Setting/Services Provided: ICU, SCU, CCU (Intensive Care Unit, Special Care Unit, Cardiac Care Unit--intensive care services; OR (Operating Suite)--operating services and anesthesia; ED (Emergency Department)--emergency services, including ambulance transport; RR (Recovery Room)--recovery room services; Gen Anes (General Anesthesia)--anesthesia services; Mod Sed (Moderates Sedation)--moderates sedation services--wherever they are provided; Pediatric PCC (Pediatric Primary Care Clinic)--pediatric acute care and primary care settings; Radiology--radiology services.

C--“Certification” requires successful completion of a standard PALS course or the equivalent. It is a biennial requirement.

T--“Training” refers to participation in a standard PALS course or the equivalent; although successful completion of the course is expected, it is not critical to the fulfillment of this requirement. It is a biennial requirement.

N/A--not applicable where the practice setting/services provided are not generally considered within the range of care of the particular provider.
3.8.3.3. NRP certification is required by any healthcare provider (physician, resident physician, nurse provider, nurse anesthetist or midwife) who is directly responsible for rendering medical care to newborns regardless of the clinical area where the care is provided. This includes all providers who attend a delivery.

3.8.3.3.1. NRP certification is required for nurses and technicians who work in Labor and Delivery, the Newborn Nursery, Neonatal Intensive Care Unit, and the Obstetrical/Post-Partum Unit.

3.8.4. Timing of training: Required life support training will be accomplished within 6 months of this publication revision, or within six months of assignment to the areas noted above, whichever is later. The local MTF/CC may grant an extension of an additional six months.

3.8.4.1. Retraining will occur every two years.

Table 3.3. NRP Requirements by Provider and Area of Work

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<tr>
<th>Provider#</th>
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#Provider: Physician (MD or DO)--regardless of specialty; PA (Physician Assistant); NP (Nurse Provider)--pediatric care nurse provider; CRNA (Certified Registered Nurse Anesthetist); Midwife (nurse midwife); Nurse (clinical nurse); Technician--advanced life support training of technicians does not equate to the granting of privileges to manage a cardiac emergency.

*Practice Setting/Services Provided: Neonatal ICU (Neonatal Intensive Care Unit)--intensive care services; OR (Operating Suite)--operating services and anesthesia; Newborn Nursery; OB, L&D (Obstetrical Unit, Delivery Rooms, Post-Partum Unit)--obstetrical services.

C--“Certification” requires successful completion of a standard NRP course or the equivalent. It is a biennial requirement.

N/A--not applicable where the practice setting/services are not generally considered within the range of care of the particular provider.

3.9. Automated External Defibrillators (AED) and Public Access Defibrillators (PAD)

3.9.1. MTFs will provide AED services as part of all basic life support provided within the MTF buildings. The MTF/CC may increase the frequency of refresher training to ensure proficiency of personnel.

3.9.2. Required AED training:
3.9.2.1. Emergency Services Departments and Education and Training will ensure that all MTF personnel involved in providing this service are trained using the AED chapter in the ACLS manual, as appropriate for the devices in that particular MTF.

3.9.2.2. Training on AED protocols is required for Emergency Services staff directly involved in patient care, and is highly encouraged for all other personnel. Aerospace Medical Service Specialty Personnel (AFSC 4N0X) assigned to emergency services, acute care clinics, back-up/on-call ambulance crews, or nursing units utilizing AEDs on crash carts must accomplish AED qualification training annually. The MTF/CC may increase the frequency of refresher training to ensure proficiency of appropriate personnel.

3.9.3. Public Access Defibrillators (PAD) are defibrillators that are intended for the use by non-medically trained individuals in public buildings. These devices, the program determining their deployment and use, purchasing and maintenance will be covered by a pending AFI 10-series, *Air Force Installation Emergency Medical Services Program* Instruction.

3.10. **Ambulance Services.** All guidance concerning Ambulance Services will be located in a future AFI 10-series instruction.
Chapter 4

MATERNAL-CHILD PRODUCT LINE

Section 4A—Preventive Services

4.1. Periodic Health Maintenance Examination

4.1.1. MTFs must ensure that there will be adequate capability to administer women’s health periodic examinations within the direct-care system or network for all female beneficiaries age 18 years and older, and for those under the age of 18 years who are sexually active. These capabilities must include at least the following: Papanicalaou smear (Pap smear), chlamydia testing for all women under 25 years of age and as otherwise appropriate, pelvic examination, breast examination, blood pressure measurement, family planning and contraceptive counseling for those desiring this service.

4.1.2. MTFs must develop policies to ensure reporting the result of Pap smears to the patient within 14 duty days from collection of the specimen. EXCEPTION: At isolated clinics or overseas locations, report the results within 30 duty days.

4.1.3. Nationally recognized guidelines, such as those published by the US Preventive Services Task Force (USPTF) or other similar authority, shall govern the frequency of periodic screening examinations. In some situations, the privileged provider may determine that a woman does not require a portion of the usual annual examination. If so, the provider will discuss the basis for that recommendation with the patient and advise her of the time frame for and the content of the next examination. This must be documented in the medical record.

4.2. Mammograms

4.2.1. Beginning at age 40, MTFs must offer screening mammograms for all active duty women and other eligible beneficiaries. The procedure may be performed in the MTF where the service is available, or in the purchased care system when the MTF cannot provide the service. The frequency of performing mammography shall be guided by discussion with the primary care provider, taking into account the patient’s risk factors and current guidelines.

4.2.1.1. Accepting self-referring/self-requesting patients, who have not had a Clinical Breast Exam (CBE) prior to the mammogram, is an acceptable practice within the AFMS. Each MTF must develop a local policy regarding self-referrals/self-requests for screening mammograms, which outlines the process how a patient may schedule the mammogram, how the PCM will be notified of the patient’s request for the mammogram, how the patient notification, identification/disposition of over-utilizers and follow-up process for clinical breast care will occur after the mammogram.

4.2.2. MTFs must make diagnostic mammography available to women at any age who have been identified by their healthcare providers as requiring additional evaluation as indicated by individual risk factors. The procedure may be performed in the MTF where the service is available, or in the purchased care system when the MTF cannot provide the service.

4.2.3. Radiology Services will provide appointments within 30 calendar days of the request for screening mammography, and within five days for diagnostic mammography.
4.2.4. Where the MTF provides the mammography service, providers (either the ordering provider or the interpreting radiologist, according to the written local practice) will notify the patient of test results within 14 duty days for screening mammograms and five duty days for diagnostic mammograms, and assist the patient to make appropriate follow-up appointments.

4.2.5. Mammograms shall only be performed at locations (in the MTF or in the purchased care system) that are accredited by the American College of Radiology, an accrediting body approved by the Department of Health and Human Services (DHHS) IAW 21 Code of Federal Regulations CFR 900, *Mammography Accreditation*, or a host nation equivalent for OCONUS locations.

4.2.6. Local policy will guide mammogram sign-out procedures:

4.2.6.1. Original mammograms will be released to the patient or to an authorized designee upon request.

4.2.6.2. Strict sign-out procedures will be instituted and maintained to ensure accountability for the films.

4.3. **Gynecological Services**

4.3.1. Acute or emergent gynecologic services must be made available in the direct or purchased healthcare system. Patients with emergent problems shall be seen immediately, and with urgent problems shall be seen within one duty day. Clarification of degree of urgency should be accomplished through discussion between the referring provider and the gynecologic services provider.

4.3.2. MTFs will ensure that routine gynecologic care is available within 30 calendar days.

*Section 4B—Family Planning*

4.4. **Family Planning Services Provided (Refer to Section 2B, Treating Minors also)**

4.4.1. MTFs will provide family planning services including contraceptives and sterilization through the direct or purchased care system. *NOTE* Medical personnel who, for moral or ethical, religious or professional grounds, object to providing family planning services need not perform or assist in such procedures unless their refusal poses life-threatening risks to the patient.

4.5. **Sterilization (Refer to Section 2B, Treating Minors also)**

4.5.1. The patient requests sterilization by signing AF Form 1302, *Request and Consent for Sterilization*. The signature of a spouse or significant other is not required.

4.5.2. MTFs may perform sterilization procedures, or refer patients to another MTF or civilian facility where the procedure is available.

4.6. **Contraceptive Services (Refer to Section 2B, Treating Minors also)**

4.6.1. Contraceptive services include counseling, prescribing oral contraceptives, or issuing, inserting or implanting devices or pharmaceuticals.
4.7. **Induced Abortion (Refer to Section 2B, Treating Minors also)**

4.7.1. Federal Law prohibits the use of DOD funds to pay for abortion in the continental United States. **EXCEPTION:** When a pregnancy would endanger a woman’s life, AFMS personnel may induce abortion. The patient’s physician and the MTF/CC (or SGH if the CC is a non-physician) must certify in the medical record that the abortion is medically necessary.

4.7.2. Overseas MTFs may perform prepaid abortions only in cases where the patient is a victim of rape or incest.

4.7.3. Medical personnel who have a personal or moral objection to abortion need not perform or assist in the abortion procedure unless their refusal poses life-threatening risks to the patient. **NOTE:** This applies only to personnel directly involved in performing the abortion procedure itself.

4.7.4. All patients (active duty and family members) must pay for the abortion, when the procedure is permitted, at the current same-day surgery rate published in the Federal Register.

4.7.5. When the patient is an adult or an emancipated minor (as determined by the applicable law), only the patient’s consent for the abortion is required. Consult the MLC or servicing staff judge advocate if there are questions of whether a patient is an emancipated minor.

4.7.6. When the patient is a minor, the healthcare provider will obtain a valid consent in one of the following ways:

4.7.6.1. Through judgment by the MTF/CC (or SGH in the event that the MTF/CC is not a physician) that the minor is mature enough and well enough informed to give her own competent consent.

4.7.6.2. If the MTF/CC or senior designated physician decides the minor is not sufficiently mature to give competent consent; at least one parent or legal guardian must consent to the procedure.

4.7.6.3. Consultation with the base legal services and the Medical Law Consultant is recommended whenever these situations arise.

4.7.7. The Air Force will respect host nation laws regarding abortion. The consent procedures described above apply in the absence of controlling host nation laws or legal requirements.

4.7.8. Any complication resulting from an elective abortion procedure will be treated as would any medical problem/complication.

**Section 4C—Medical Care Related to Pregnancy**

4.8. **Standards (Refer to Section 2G--Newborn Care also)**

4.8.1. The Air Force adheres to the *Newborns’ and Mothers’ Health Protection Act of 1996*, and respects the standards published in the American College of Obstetricians and Gynecologists (ACOG) *Manual of Standards in Obstetric-Gynecologic Practice* and ACOG technical bulletins. In certain situations, an MTF may need to develop more specific guidance. All hospitals offering labor and delivery services shall be equipped to perform emergency Cesarean section delivery per the guidelines published by the American College of Obstetricians and Gynecologists.

4.8.2. IAW the *Newborns’ and Mothers’ Health Protection Act*, the following standards are expected:
4.8.2.1. Inpatient maternity care provided by the AFMS will be available for a minimum of 48 hours following a normal delivery, and for a minimum of 96 hours following delivery by Cesarean section. No additional approval or authorization is needed for care that falls within these guidelines.

4.8.2.2. The length of post-delivery hospital care shall involve consideration of maternal and infant health, a psychosocial assessment of the family’s ability to care for a newborn infant, and the availability of follow-up care for both mother and infant.

4.8.2.3. A mother and her newborn may be discharged from the hospital in less than 48 or 96 hours, providing that the decision is made by the attending provider(s) in consultation with the infant’s mother.

4.8.2.4. Adherence to this policy does not require a beneficiary to either give birth in a hospital, or to stay in the hospital for a fixed period of time following the birth of a child.

4.8.3. The AF SG endorses the policy of ACOG and AAP Guidelines for Perinatal Care, “Because intrapartum complications can arise, sometimes quickly and without warning, ongoing risk assessment and surveillance of the mother and the fetus are essential. The hospital, including a birthing center within a hospital complex, provides the safest setting for labor, delivery and the postpartum period. This setting ensures accepted standards of safety that cannot be matched in a home birthing situation.” Due to these concerns, the Air Force does not favor home delivery. If an elective home delivery on base is planned nonetheless, the installation Commander, in consultation with the MTF/CC, will first ascertain to his/her satisfaction whether the provider participating in the delivery is properly licensed by the host jurisdiction to perform the procedure and that the welfare of personnel on base is not jeopardized.” Consequently, the Air Force does not support or endorse home delivery.

4.9. Trial of Labor for Vaginal Birth after Cesarean Section (VBAC).

4.9.1. MTFs shall provide the option for trial of labor for vaginal birth after cesarean section. Options include attempting a trial of labor at the local MTF, referring the patient to local civilian care or offering aeromedical evacuation to an MTF that has the ability to provide this service.

4.9.2. MTFs providing a trial of labor to attempt a vaginal birth after Cesarean section must have an obstetric provider with cesarean section privileges, a privileged provider of anesthesia (anesthesiologist or anesthetist), and surgical support to include one skilled first assistant, circulating nurse, and scrub technician available in-hospital for the duration of active labor and delivery to perform an emergency cesarean section.

4.9.3. Trial of labor to attempt a vaginal birth after cesarean section is NOT a contraindication to receiving epidural anesthesia for labor and delivery, or for the use of an oxytocic agent for induction or augmentation of labor.

4.9.4. Misoprostil (Cytotec) shall NOT be used for cervical ripening or induction of labor in patients who have had a previous cesarean delivery or major uterine surgery.

4.10. Epidural Anesthesia for Delivery

4.10.1. MTFs shall provide the option of epidural anesthesia or analgesia for normal vaginal deliveries. Options include performing the procedure at the local MTF, referring the patient to local civilian care and offering aeromedical evacuation to an MTF that has the ability to provide this service.
4.10.2. A physician with obstetrical privileges, or a similarly privileged provider fully familiar with the case will remain readily available to manage the patient’s progress. “Readily available” will be defined by MTF policy, based on the local situation.

4.10.3. A physician with cesarean section privileges must concur with the plan of management.

4.11. Use of Oxytocic Drugs in Pregnancy

4.11.1. Prior to the initiation of an oxytocic agent, a provider privileged in obstetrics (obstetrician, family physician or certified nurse midwife) must personally evaluate the maternal and fetal status and progress of labor. When oxytocin is used during labor, a provider with Cesarean section privileges shall be readily available. “Readily available” will be defined by MTF policy, based on the local situation. Personnel familiar with the effects of oxytocin and who are able to identify maternal and fetal complications shall be in attendance during administration of oxytocin.

4.11.2. A physician with Cesarean section privileges must concur with the plan for using the oxytocic agent, the management of labor, and, along with the facility, must be prepared to initiate Cesarean section within 30 minutes of the time the decision is made that Cesarean section is indicated.


4.12.1. Duty Restriction Recommendations: Duty restriction recommendations are made by the patient’s obstetrical healthcare provider, working with Public Health personnel, Bioenvironmental Engineering, Flight Medicine and the patient’s supervisor. The obstetrical healthcare provider:

4.12.1.1. Recommends restricted duty for active duty pregnant personnel based on the patient’s work environment and the patient’s overall medical condition.

4.12.1.2. Documents the duty restrictions on AF Form 422, Physical Profile Serial Report, and forwards the form to the Force Health Management section. A profile officer in either Flight Medicine or Occupational Medicine will ensure that the occupational hazards affecting pregnancy have been addressed in the restrictions, and that the member’s profile is changed to a 4T, disqualifying the member from deployment. Refer to AFI 36-2110, Assignments, for details.

4.12.1.3. The 4T profile will remain in effect until the completion of any post-pregnancy convalescent leave. Force Health Management will ensure the duty restrictions are sent to the member’s Military Personnel Flight (MPF) and to the member’s unit. Duty restrictions are based upon the recommendations of the attending physician and must include specifics such as number of hours to be worked in a week, or if 10-hour work days, number of ten-hour work days per week. The member’s unit and the member are responsible for notifying the respective unit deployment manager (UDM) of the medical condition.

4.12.1.4. In all cases, the duty restriction shall attempt to balance the patient’s medical needs with the rights of the military member to fully participate in unit activities.

4.12.1.5. When the obstetrical healthcare provider is a civilian, recommendations will be reviewed by a military medical provider (PCM) through the Force Health Management section, who will make a final duty recommendation to the military member and her supervisor.

4.12.2. The Air Force Reserve Component (AFRC) and the Air National Guard (ANG) medical units use public health recommendations along with appropriate Reserve and Guard directives to complete AF Form 422.
4.12.3. For Individual Mobilization Augmentees (IMA) the unit of attachment completes the AF Form 422 using base public health procedures, and sends a copy to Headquarters, Air Reserve Personnel Center (HQ ARPC/SGP) for disposition.

4.13. Chemical Warfare Defense Ensemble (CWDE) during pregnancy

4.13.1. Pregnant Military Members

4.13.1.1. May not participate in mask confidence training (Refer to AFMAN 32-4006, Nuclear, Biological, and Chemical (NBC) Mask Fit and Liquid Hazard Simulant Training, chapter 3 also), i.e. enter the confidence chamber.

4.13.1.2. Less than 20 weeks gestational age, the member may wear or carry CWDE until it no longer fits, and during exercises, excluding the confidence chamber, use the following ambient temperature guidelines:

4.13.1.2.1. If the temperature is below 70 degrees Fahrenheit, the member may wear the full ensemble.

4.13.1.2.2. If the temperature is above 70 degrees Fahrenheit, the member shall wear only the mask, hood and helmet. The chemical protective suit is carried. The member will not wear or carry the flak vest or web belt.

4.13.1.3. After 20 weeks gestation, the member must demonstrate proficiency in donning the mask at the beginning of exercise or training, but not participate in the confidence chamber. After completing the proficiency demonstration, the member may carry the mask but does not have to use it. The member does not carry or wear the helmet, flak vest, web belt or chemical protective suit. All activities involving exercises or training shall be with the approval of the obstetrician or PCM with documentation on the AF Form 422.

4.14. Assignment Curtailment in Isolated or Remote Areas

4.14.1. Pregnant members assigned to areas without obstetrical care will have their assignments curtailed by the 24th week of pregnancy or earlier and are reassigned by AFPC.

4.14.2. If local medical personnel are not capable of managing the early complications of pregnancy or the pregnancy is complicated; the member’s assignment shall be immediately curtailed.

4.15. Breastfeeding and Breast Pumping

4.15.1. AF members shall be authorized 15-30 minutes every 3-4 hours to breast-pump. This should be allowed for approximately 12 months after delivery.

4.15.2. The obstetrician or PCM shall annotate on an AF Form 422 that the member wishes to breast pump and makes a request for a room or office that provides adequate privacy for breast pumping be designated to allow AF members to pump. The AF member must supply the equipment needed to breast pump and store the breast milk.

4.15.3. The obstetrician, pediatrician or PCM shall annotate on an AF Form 422 a recommendation for deployment for those AF members who choose to exclusively breastfeed, i.e. the infant does not take formula at all.
4.15.4. Breastfeeding/breast pumping AF members may participate in field training and mobility exercises. Decisions to continue to breast pump must be made by the patient, in collaboration with obstetrician or PCM, supervisors, training instructors and the MDG/CC in regard to having a place to safely express and store breast milk.

4.16. Weight and Fitness Compliance

4.16.1. Postpartum active duty women must comply with the Air Force Fitness Program by six months after delivery or as recommended by their active duty obstetrical provider, or their active duty primary care manager with obstetrical consultation where the member’s obstetrician is a civilian.

4.17. Illness During the Prenatal Period

4.17.1. Providers may not recommend convalescent leave during the prenatal period for pregnancy-related time off work.

4.17.2. Providers may authorize quarters as usual for up to 72 hours for medical issues not related to the pregnancy. For issues related to the pregnancy, use Obstetrical Quarters (OB Quarters) status. **NOTE:** There is no duration limitation on OB Quarters, but the attending provider must evaluate the patient at least weekly and document this evaluation in the medical record.

4.17.3. Providers place prenatal patients discharged from inpatient status, but medically unable to return to duty, in Subsisting-Elsewhere Status.

4.18. Evaluation of Pregnant Civilian Employees

4.18.1. When a civilian who is employed by the Air Force presents confirmation of pregnancy to the supervisor, the supervisor refers her to Public Health.

4.18.2. Bio-Environmental Engineering (BEE) evaluates workplace risks in conjunction with Public Health and Flight Medicine, advises the employee of any identified risks, and reports the risks with any recommended techniques for avoiding the risks to the employee and her supervisor.

4.18.3. When the obstetrical healthcare provider is a civilian, recommendations will be reviewed by a military medical provider through the Force Health Management section, who will make a final duty recommendation to the civilian employee and her supervisor.

Section 4D—Newborn Care

4.19. Inborn Diseases

4.19.1. MTFs must develop written policies and procedures for screening and treatment programs using state health requirements and the guidelines in the most recent edition of *Guidelines for Perinatal Care*, prepared by the American Academy of Pediatrics (AAP) and ACOG.

4.19.2. MTFs must ensure sickle cell screening is included in routine newborn screening (not included in some state newborn screening panels).

4.19.3. MTFs must ensure newborn hearing screening is performed. This is provided by many facilities as a standard portion of perinatal care. **NOTE:** This is not a TRICARE covered benefit.
4.20. **Newborn and Intensive Care Nurseries**: Refer to the most recent edition of *Guidelines for Perinatal Care* for functional capabilities, physical plant, equipment and procedures for intensive care and transfer plans for newborns.

4.21. **Newborn Hospital Stay**

4.21.1. Every breastfeeding infant shall have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement and instruction as recommended in the AAP statement *Breastfeeding and the Use of Human Milk* (1997).

4.21.2. For newborns discharged less than 48 hours after delivery, the PCM or attending physician shall provide follow-up IAW AAP statement *Hospital Stay for Healthy Term Newborns* (1995). It is essential that all infants having a short hospital stay be examined by experienced healthcare providers within 48 hours of discharge. If this cannot be assured, then discharge shall be deferred until a mechanism for follow-up evaluation is identified. Mother and infant shall be evaluated individually to determine the optimal time of discharge. The timing of discharge shall be the decision of the physician caring for the infant and not by policy established by third-party payers.
Chapter 5

MEDICAL SERVICES PRODUCT LINE

Section 5A—Reportable Diseases and Conditions

5.1. What and How to Report

5.1.1. Providers shall report diseases and conditions of public health or military significance as defined in the installation reportable events list developed annually by the Public Health staff, as well as any other unusual conditions or clusters to the Public Health Office IAW AFI 48-105, Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance.

5.1.2. Providers shall report all suspected or confirmed occupational illnesses and injuries, conditions of public health significance (including work related musculoskeletal disorders) to the public health office IAW AFMAN 91-224, Ground Safety Investigations and Reports.

Section 5B—Acquired Immune Deficiency Syndrome (AIDS)

5.2. Infected Healthcare Workers.

5.2.1. Privileged providers infected with the human immunodeficiency virus (HIV) will have their clinical privileges and/or duties evaluated by the Chief of the Medical Staff and MTF Credentials Function after each re-evaluation at the Infectious Disease Department at Wilford Hall Medical Center and upon requesting privileges at a new base.

5.2.2. The Credentials Function, in cooperation with the Infection Control Committee and the provider’s personal physician, will recommend to the MDG/CC, the scope of practice for HIV infected healthcare workers. Clinical privileges will be reassessed on an annual basis, more frequently if the provider’s clinical status changes. Any revocation, denial, or limitation of clinical privileges requires reporting to AFMOA/SGOC, and shall be conducted IAW AFI 44-119.

5.2.3. Non-privileged healthcare workers infected with the human immunodeficiency virus (HIV) will have their duties evaluated by the Chief of the Medical Staff/Chief Nurse Executive, after each re-evaluation at the Infectious Disease Department at Wilford Hall Medical Center and upon requesting privileges at a new base.

5.3. HIV-Infected Patient Referral.

5.3.1. Medical personnel must refer Air Force active-duty members with suspected or newly diagnosed HIV infections to the 59th Medical Wing (Wilford Hall Medical Center), Lackland AFB, TX for definitive diagnosis, treatment, and disposition. **NOTE:** Suspicion means that initial testing (ELISA and Western Blot) is positive. Refer to AFI 48-135, Human Immunodeficiency Virus Program for additional details.

Section 5C—Blood-borne Pathogen Infected Healthcare Workers

5.4. Hepatitis B Infected Healthcare Workers.
5.4.1. All healthcare workers are required to know whether or not they have been infected with hepatitis B IAW current Occupational Safety and Health Administration (OSHA) guidelines.

5.4.2. Healthcare workers who are at risk for transmitting hepatitis B, as manifest by the presence of serum hepatitis B e antigen (HBeAg), or positive hepatitis B DNA, will have their clinical privileges evaluated by the MTF Credentials Function for potential for transmitting hepatitis B during invasive procedures. The Credentials Function, in consultation with the Infection Control Committee, will recommend to the MDG/CC, the scope of practice for healthcare workers who are positive for HBeAg or Hepatitis B DNA. The MDG/CC will make the final determination on what privileges are granted in light of the provider’s health status. Any revocation, denial, or limitation of clinical privileges requires reporting to AFMOA/SGOC, and shall be conducted IAW AFI 44-119.

5.4.2.1. It is DOD policy that the Credentials Functions shall recommend curtailment of the privileges of providers who are at high risk for transmitting hepatitis B, as shown by positive serum hepatitis B surface antigen and positive serum hepatitis B e antigen or positive serum hepatitis B DNA, in such invasive procedures as cardiac surgery.

**Section 5D—Medical Nutrition Therapy**

5.5. **Medical Nutrition Therapy (MNT)** is an intrinsic part/component of clinical practice and includes: clinical nutrition assessment, diet modification and counseling and specialized nutrition therapy.

5.5.1. At a minimum, MNT must be made available for patients with the following medical conditions: diabetes, pediatric failure to thrive, dyslipidemia, hypertension, malnutrition, high-risk pregnancy, renal disease and complicated inflammatory bowel disease.

5.5.2. MNT is obtained via referral to the Nutritional Medicine Service, a registered dietitian, or to authorized enlisted staff members who have completed specialized training in dietary therapy.
Chapter 6

SURGICAL SERVICES PRODUCT LINE

Section 6A—Performing Surgical Procedures

6.1. Qualified Assistants. The operating surgeon shall ensure a qualified first assistant is present for surgical procedures with a high risk of significant mortality or morbidity. This may be an appropriately trained physician, dentist, nurse or physician assistant. Qualified nurses, physician assistants or technicians may function as a second or third assistant.

6.2. Elective Surgery. Elective surgery, performed at the member's expense, is prohibited without prior written approval of the member's squadron commander and the MTF/CC. This permission must be obtained prior to any non-refundable deposits (for surgery, airline tickets, etc) being made; the potential for lost deposits will not be factored into the decision. The mission, unit manning status, potential for complications, and effect on upcoming deployments or PCS moves will be considered on an individual basis. In addition, elective surgeries within six months of separation or retirement must have additional prior approval by HQ AFPC/DPAMM, as required IAW AFI 48-123, para 5.5.4.

6.3. Cosmetic Surgery

6.3.1. Only privileged staff and residents in the specialties of plastic surgery, dermatology, otolaryngology, ophthalmology, and oral-maxillofacial surgery may perform cosmetic surgery procedures. Contract providers are not to perform cosmetic surgery procedures. Civil service providers may perform cosmetic surgery procedures only if they are employed full-time by the medical treatment facility (MTF) with no other opportunity to maintain their skill in cosmetic surgery. All patients, including active duty personnel, undergoing cosmetic surgery must pay applicable fees for cosmetic surgery. This restriction excludes the excision or destruction of minor benign dermatologic lesions, which may be performed by qualified providers in any specialty. Waiver authority to this policy is the AFMOA/CC for requests for supplemental privileges for cosmetic surgery procedures to other uniformed and civil service specialists, on a case by case basis, providing adequate documentation of training and proficiency is submitted.

6.3.2. Cosmetic surgery may be performed on a “space-available” basis only, and cosmetic surgery procedures may not exceed 15% of any privileged provider’s caseload.

6.3.3. All cosmetic procedures will be coded in the Ambulatory Data Module (ADM) with the proper International Classification of Diseases (current version) code. At present, the appropriate ICD-9-CM codes are in the V50 series: “Elective surgery for purposes other than remediying health status.” Code V50.1, “Other plastic surgery for unacceptable cosmetic appearance,” is the proper code unless a more specific code exists in this series. Code V51, “Aftercare involving the use of plastic surgery (excludes cosmetic plastic surgery)” may be used to indicate that a procedure is not cosmetic plastic surgery.

6.3.4. The MTF/CC will establish a prepayment schedule for all patients and a tracking system for all cosmetic procedures, IAW the annual publication of the DOD Medical Reimbursement Rates and Procedures document.
6.4. **Ambulatory Procedure Visits.** Each MTF will establish a list of authorized procedures that may be accomplished in an ambulatory setting, IAW DOD Instruction 6025.8, *Ambulatory Procedure Visits.*

6.5. **Corneal Refractive Surgery**

6.5.1. Performance of refractive surgery on Air Force personnel (all active duty, guard and reserve components) are detailed in the most current policies, with all supporting documents, including forms, on the SGOA web page at: [https://kx.afms.mil/ctb/groups/dotmil/documents/afms/knowledgejunction.hcst?doctype=subpage&functionalarea=AerospaceMedicine&doc-name=CTB_014680](https://kx.afms.mil/ctb/groups/dotmil/documents/afms/knowledgejunction.hcst?doctype=subpage&functionalarea=AerospaceMedicine&doc-name=CTB_014680)

6.5.2. Active duty, guard and reserve personnel who are aviation or special duty personnel who undergo refractive surgery in an MTF must go through a Photorefractory Keratectomy (PRK) waiver process, and could be permanently disqualified from flying/special duty if they no longer meet AFI 48-123 standards.

6.5.3. Radial Keratotomy (RK), Intrastromal Ring Segments (INTACS), and Laser-In Situ-Keratomileusis (LASIK) may be disqualifying for aviation and special duty personnel. RK and INTACS are currently not allowed on any active duty USAF personnel. LASIK is allowed on USAF Space and Missile Operations Personnel as per SG policy letter (#00-005 & #04-001) and can be obtained at the member’s own expense at a civilian source after obtaining their commander’s permission.

6.5.4. Location for Refractive Surgery Procedures: Pilots and boom operators must have their refractive surgery performed at Wilford Hall Medical Center, Lackland AFB, TX, after undergoing an aero-medical ophthalmologic evaluation at Brooks City Base, TX (by the Aeromedical Consultation Service). Active duty aviation and special duty personnel, other than pilots and boom operators, can receive their refractive surgery at any other USAF Laser Center. All other active duty personnel can receive their refractive surgery at any DOD Laser Center, or at their own expense from a civilian ophthalmologist after obtaining their commander’s and the MDG/CC permission.

6.5.5. Regardless of the location of the procedure or the status of the member, all personnel must obtain their commander’s permission, and follow all other requirements outlined in the SG refractive surgery policy letters.

**Section 6B—Anesthesia Policy, Practice and Services**

6.6. **Responsibilities**

6.6.1. The Chief Consultant to the Air Force Surgeon General for Anesthesiology, working through HQ AFMOA/SGOC provides guidance in force distribution, readiness issues and anesthesiology practice.

6.6.2. The MTF/CC designates a physician responsible for clinical oversight of MTF anesthesia services as the Chief of Anesthesia. Where there is no physician anesthesia provider, a certified registered nurse anesthetist (CRNA) may fulfill this role.

6.6.3. The Chief of Anesthesia is responsible for the scheduling of anesthesia services, and is a privileged anesthesia provider. The Chief also:

6.6.3.1. Ensures daily assignments consider the patient’s condition and clinical requirements, and that these needs are coordinated with the Operating Room Supervisor and the attending surgeons.
6.6.3.2. Ensures that personnel develop a fail-safe mechanism to track the controlled drugs used by anesthesia services.

6.6.3.3. Ensures there is always a back-up provider (float) available in the event of an emergency. The backup provider can be another anesthesia provider or another physician capable of immediately diagnosing and treating a medical emergency.

6.7. Certified Registered Nurse Anesthetists (CRNA) (Refer to also AFI 44-119, which delineates scope of practice issues).

6.7.1. Appropriately privileged CRNA’s may routinely administer anesthesia to:

6.7.1.1. Children two years of age and older.

6.7.1.2. Patients in American Society of Anesthesiology (ASA) risk classification category II or lower risk.

6.7.2. CRNAs will consult with an anesthesiologist before providing care to children under the age of two years or to patients in ASA class III or higher. This consultation may be verbal or electronic, and must be documented in the medical record. This also applies where the consulting anesthesiologist is not assigned to the same MTF.

6.8. Managing Controlled Substances on the Anesthesia Service

6.8.1. The Anesthesia Service:

6.8.1.1. May keep no more than a one-week supply of controlled substances.

6.8.1.2. Must keep controlled substances in double-locked cabinets (may be located on the anesthesia carts as required, or separately).

6.8.2. The Chief of Anesthesia appoints an anesthesia provider as the Officer-in-Charge (OIC) of controlled substances in anesthesia.

6.8.3. A CRNA or anesthesiologist carries the keys to the controlled substances cabinets during duty hours.

6.8.3.1. The on-call anesthesia provider carries the keys after duty hours.

6.8.4. Personnel must never leave the day’s supply of controlled substances unattended on anesthesia carts.

6.8.5. The OIC for controlled substances in anesthesia is responsible for a daily inventory of all controlled substances. The inventory is to be conducted by an anesthetist and another officer who is not an anesthetist.

6.8.6. Personnel must address appropriate controlled substance dosages as part of the monthly anesthesia audit.

6.9. Use of AF Form 579, Controlled Substances Register

6.9.1. All anesthesia personnel utilizing controlled substances must comply with the following:

6.9.1.1. An AF Form 579 must be maintained for each controlled substance stocked by the anesthesia service.
6.9.1.2. Controlled substances must be signed out, at the time they are obtained from the cabinet, by the ampule, vial or syringe.

6.9.1.3. Any unused or unopened ampule, vial, or syringe must be signed back into stock using the received column on AF Form 579.

6.9.1.4. All controlled substances administered to the patient must be shown in 2 places on the anesthesia record (document the dosage appropriately).

6.9.1.5. Show incremental doses of controlled substances on the anesthesia record, and annotate the time given.

6.9.1.6. Enter a summary of all controlled substances administered to a patient and partial unit dosages wasted on the anesthesia record, and on any other local form as required. The anesthesia personnel assigned to the case must sign this summary entry. If personnel waste, drop, or contaminate partial unit doses, a professionally licensed officer must co-sign the summary entry. EXCEPTION: If another professionally licensed provider or nurse is not available, a medical, surgical or dental journeyman or craftsman may witness and co-sign the entry IAW local policy and procedures.

6.9.1.7. IDMT’s will follow established anesthesia procedures IAW AFI 44-103.

6.9.1.8. The total amount of controlled substances administered, returned, and destroyed must match the net amount of the drug issued on the AF Form 579.

6.9.1.9. All incorrect balances and unaccountable substances will be reported to the SGH, the Chief of Pharmacy Services, or the Chief of Surgical Services. An AF Form 765, Medical Treatment Facility Incident Statement, will be completed promptly and forwarded to the facility Risk Manager. AF Form 85A, Inventory Adjustment Voucher, must also be completed.

6.9.2. Availability of Anesthetics. Anesthesia personnel:

6.9.2.1. Must have induction agents immediately available.

6.9.2.2. Control these drugs according to guidelines in Chapter 10, Pharmacy Services.

6.9.2.3. During the elective surgery schedule, stock all anesthesia carts with adequate supplies of induction agents.

6.9.2.4. Stock emergency and obstetrical anesthesia carts with adequate supplies for immediate use. Stock additional supplies along with other anesthesia drugs in a controlled area, workroom, and/or refrigerator.

6.9.2.5. Although personnel must keep an accurate record of incremental doses of drugs administered on anesthesia record, they need not record this type of drug on AF Form 579 under usual circumstances.

6.10. Processing and Completing Records

6.10.1. The anesthesiologist or the CRNA (the latter with the concurrence of the physician or dentist who countersigned the pre-operative assessment) will:

6.10.1.1. Establish an anesthetic plan and document this on the anesthesia record. A CRNA note must document the case was discussed with an anesthesiologist or be countersigned preoperatively for ASA 3 or higher cases and those involving children under the age of 2. All other CRNA
pre-operative assessments must be countersigned by an anesthesiologist, surgeon or dentist before the chart is closed.

6.10.1.2. Write pre-operative orders for the patient on the AF Form 3066, Doctor’s Order or appropriate electronic record in use at that time.

6.10.1.3. Accompany the patient from the procedure room to the Post-Anesthesia Care Unit (PACU).

6.10.1.4. Promptly complete the record at the end of each procedure.

6.10.2. Procedures performed by anesthesia providers not requiring an anesthesia record shall be documented in the medical record.

6.10.3. The PACU nurse records all pertinent information regarding the patient’s recovery from anesthesia. Local policy will define the parameters used for discharge or transfer.

6.10.4. The physiological parameters at the time of the transfer/discharge must be clearly documented in the patient’s record, along with discharge instructions, and a reference as to in whose care/custody the patient is released.

6.10.5. The unit nurse receiving the patient makes an entry on the medical record.

Section 6C—Use of Sedation for Clinical Procedures

6.11. Use of Sedation for Clinical Procedures

6.11.1. Sedation is part of the continuum of anesthesia. Definitions of the three levels of sedation are:

6.11.1.1. Minimal sedation (anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilation and cardiovascular function are unaffected. Patient care areas providing minimal sedation (anxiolysis) by oral pre-medication only may rely on standard peer review procedures.

6.11.1.2. Moderate sedation/analgesia (conscious sedation) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is normally maintained.

6.11.1.3. Deep sedation/analgesia is a drug-induced depression of consciousness during which the patient cannot be easily aroused, but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function usually is maintained.

6.11.2. Facilities must develop institution-wide protocols, with approval by the Executive Committee of the Medical Staff (ECOMS) for use of sedation to ensure consistency in all patient care settings.

6.11.2.1. This includes guidance for both physicians and dentists, defining what must be included in a pre-sedation history and physical, and when the history and physical is to be performed in relation to the actual surgery.

6.11.3. Providers appropriately privileged to perform sedation determine the selection and use of oral or intravenous sedation. Peer review, with approval by the Executive Committee of the Medical Staff
(ECOMS), of sedation protocols is required, and will be accomplished IAW the MTF’s program, under the purview of the SGH.

6.11.4. Medical personnel must monitor sedated patients and be prepared for emergencies. This requires:

   6.11.4.1. Qualified assistants. A qualified assistant must have current Basic Life Support certification (ACLS or PALS training is recommended, depending on the patient’s age, but not required unless the assistant is administering the medications), and familiarity with the cardiovascular and respiratory side effects of the agents used. A qualified assistant must be trained in the use of monitoring equipment, be trained in the recognition and management of medical emergencies, and be familiar with code blue procedures and the contents of the crash cart.

   6.11.4.2. An emergency notification system.

   6.11.4.3. Monitoring equipment for blood pressure determination, cardiac rhythm and oxygen saturation will be readily available. All sedated patients will be visually monitored for level of consciousness and respiratory rate.

   6.11.4.3.1. When the patient is minimally sedated (anxiolysis), further monitoring will be provided as deemed necessary by the treating provider (if greater than 50% nitrous oxide is utilized, oxygen saturation and heart rate shall be monitored).

   6.11.4.3.2. When the patient is moderately sedated, oxygen saturation, heart rate and blood pressure will be monitored. Any additional monitoring may be utilized as deemed necessary for the particular care of an individual patient.

   6.11.4.3.3. When deep sedation is utilized, oxygen saturation, heart rate, blood pressure, and cardiac rhythm will be monitored. Equipment to monitor temperature will be immediately available. Additional monitoring may be utilized as deemed necessary for the particular care of an individual patient.

   6.11.4.4. Resuscitative equipment and medications are rapidly accessible.

6.11.5. A privileged provider or qualified ACLS and/or PALS certified clinical nurse may infuse intravenous medication.

Section 6D—Living Organ and Tissue Donation Participation for Transplantation or Research

6.12. Organ and Tissue Procurement Planning

   6.12.1. IAW DOD Directive 6465.3, Organ and Tissue Donation, all CONUS inpatient facilities must establish an organ and tissue procurement plan in conjunction with the nearest military transplant center (MTC) and local organ procurement organization and to measure the effectiveness of their organ procurement effort. This must be documented in a Memorandum of Understanding (MOU) or a Memorandum of Agreement (MOA), which will require local legal review before enactment.

   6.12.2. Consistent with donor intent, all organs and tissues retrieved from DOD beneficiaries who had previously signed an organ donation consent form are first offered to one of the established MTC’s.

   6.12.3. DOD bills its retrieval costs to civilian organ procurement organizations or non-DOD transplant recipients as outlined in the current TRICARE Policy Manual, which can be accessed at: http://www.tricare.osd.mil/tricaremanuals/.
6.12.4. An affirmative or negative organ or tissue donation shown on a DOD-issued card or in a DOD-maintained database shall be considered by medical personnel to be guidance to the next of kin. If there is conflict with State law, donor election or donation documentation, medical personnel may follow local applicable law.

6.12.5. MTF personnel shall immediately notify the Organ Procurement Organization (OPO) regarding any death, imminent death or when they recognize the potential for organ and/or tissue donation.

   6.12.5.1. Organ and tissue donation shall be discussed with the next-of-kin in every death in military MTFs unless the potential donor is determined to be medically unsuitable by the OPO or if the patient previously elected not to participate as a donor. This discussion or determination of unsuitability will be documented in the medical record.

   6.12.5.2. The MTF shall maintain a listing of patients who die and record the results of action taken to secure the donation of organs or tissues from each patient who dies.

6.13. Living Organ and Tissue Donation Participation

6.13.1. The DOD encourages, while avoiding coercion, all personnel covered under the DOD health-care system to donate tissues and organs and to advise their next of kin about their decision and any subsequent change in their decision.

   6.13.1.1. The MTF/CC will ensure that each officer and enlisted member will receive appropriate information about tissue donation during initial training or at his or her first duty station.

6.13.2. When an active duty member wishes to be a living organ or tissue donor, the following process is followed:

   6.13.2.1. The member is made aware of the risks and benefits of the procedure, including where complications might limit or prohibit further active duty service. Member provides a letter requesting to be an organ donor that is forwarded to AFMOA/CC with the request to become a living donor.

   6.13.2.2. MTF/CC ensures the member has the permission of his/her commander. The permission letter becomes part of the approval package.

   6.13.2.3. MTF/CC documents that the member can be reasonably be expected to remain physically qualified for worldwide duty after the donation, and provides a letter to AFMOA/CC to that effect, along with the member’s request, and the commander’s approval letters.

6.13.3. Donations made by active duty personnel must be approved by the Surgeon General (SG). AFMOA serves as the AF/SG approval authority, and will issue the SG approval letter on receipt of the items outlined in 6.15.2.

6.13.4. The time allotted for an active duty member to serve as an organ donor will vary based on the procedure required.

   6.13.4.1. AFI 36-3003, Military Leave Program, Table 7, Rule 39, allows the member’s commander to approve up to 10 days of permissive TDY if the unit mission allows.

   6.13.4.2. When the member is admitted to the inpatient service, they are placed in inpatient status.

   6.13.4.3. The member will be placed on convalescent leave IAW military medical authority for an appropriate period of time after the procedure.
6.13.5. Post-Mortem Sperm Donation

6.13.5.1. MTF/CC shall ascertain whether post-mortem sperm collection is offered in the local community, and if so, shall generate an MOU or MOA to delineate the administrative process for accomplishing the sperm collection. If this procedure is not offered locally, the MTF/CC has no further obligation to locate such services.

6.13.5.2. If an individual seeks post-mortem collection of sperm from a deceased AF member, the MTF/CC must determine if there are stipulations, in writing, by the deceased service member, that the deceased member has consented to the collection of sperm for the purpose of procreation, and has specifically identified the recipient of the sperm as the individual seeking the sperm.

6.13.5.3. All costs associated with collection, transport, storage and subsequent use of the sperm will be borne by the requesting individual.

6.13.6. AF participants in the DOD Marrow Donor Program will follow the same process as other organ donors; the DOD program command permission letters meet the requirement for documenting command permission.
Chapter 7

MANAGED CARE

7.1. Managed Care

7.1.1. The AFMS is part of a managed care system that strives to provide the highest possible quality healthcare at the least resource cost (best value healthcare) through an effective relationship with the TRICARE Management Activity (TMA), Managed Care Support Contractors, the Services’ medical departments, and beneficiaries that emphasizes satisfaction for our patients and other customers.

7.2. TRICARE

7.2.1. The TRICARE Policy Guideline promulgated by the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA) will be implemented by all MTFs. Current guidelines are found at http://www.tricare.osd.mil/.
**Chapter 8**

**CLINICAL LABORATORY AND ANATOMIC PATHOLOGY SERVICES**

*Section 8A—General Guidance*

8.1. **General Guidance**

8.1.1. Each MTF follows DOD standards of laboratory practice defined in the DOD Clinical Laboratory Improvement Program (DOD CLIP) for registration, certification, proficiency testing, patient test management, quality control, personnel, quality improvement and inspection. Each MTF ensures that laboratories are inspected and accredited by the College of American Pathologists, JCAHO or other accreditation programs approved by the Office of the Secretary of Defense, Health Affairs.

8.1.2. Each MTF prepares a laboratory guide with

8.1.2.1. A list of specific examinations and services it provides.

8.1.2.2. Specific instructions covering the submission of specimens and requests.

8.2. **Laboratory Services**

8.2.1. The MTF/CC designates a Chief, Laboratory Services. In most cases, this will be a biomedical laboratory officer. If a laboratory officer is not assigned to the facility, a qualified medical director may assume the additional duty of Chief, Laboratory Services.

8.2.2. The MTF/CC designates a Medical Director. The MTF/CC appoints a staff physician trained IAW DOD CLIP requirements as medical director in situations where there is no assigned pathologist.

*Section 8B—Blood Transfusion Services*

8.3. **Transfusion Services/Blood Donor Centers (BDC)**

8.3.1. The laboratory chief ensures the transfusion service or blood donor center operates under the control of a trained, competent and experience staff. Compatibility testing procedures shall adequately safeguard the intended recipient.

8.3.2. The operation shall conform to military directives and current Good Manufacturing Practices (cGMP) as required by the Food and Drug Administration (FDA), AABB (formerly the American Association of Blood Banks), AFI 44-105, *The Air Force Blood Program*, and guidance from the Air Force Medical Operations Agency (AFMOA) to include the Air Force Blood Program Division.

8.3.3. Patients, or their guardians in the case of minors, who expect to receive blood product transfusions shall complete AF Form 1225, or suitable substitute/local form. This form documents the discussion between patient and provider regarding the risks and benefits associated with blood transfusions as well as the alternatives to receiving allogeneic blood. Also see paragraph 2.4., *Informed Consent Documentation* and Section 2C, *Treating Minors*; paragraph 2.6., *General Guidelines*:

8.3.4. The administration of blood products is documented on SF518, *Blood or Blood Component Transfusion Medical Record*, or suitable substitute/local form to permanently capture all events and essential patient information associated with blood product administration. When the blood product is
known to be non-US, non-FDA licensed, the transfusion service/ blood bank shall annotate the status of that product in the Remarks block of Section II. The annotation will state: “Non-US, non-FDA licensed product, patient follow-up testing is required.”

8.4. Non-FDA Licensed Blood Transfusion Follow-up

8.4.1. DOD policy provides that the standard of care for those beneficiaries who receive a blood transfusion overseas in a DOD medical treatment facility (MTF) shall be equal to that received in a MTF within the United States. Inspection and regulatory requirements over blood and blood products vary widely by country and even within certain countries, and may not provide for the same level or type of testing as the US Food and Drug Administration (FDA) requires.

8.4.2. Non-FDA licensed blood products received for use in DOD MTFs may be used for the emergent treatment of DOD beneficiaries.

8.4.2.1. Examples of non-FDA licensed blood products include blood products collected by a “host nation” (foreign country) and provided to a DOD MTF or forward deployed EMEDS facility, blood collected under emergency conditions and transfused before FDA-approved blood donor tests are completed, or blood products that are transfused in a “host nation” (civilian or military) hospital.

8.4.2.2. Under such circumstances the attending physician or PCM (at DOD MTF) will verify and document the use of untested blood products (by FDA standards) follow-up testing is required for patient care.

8.4.2.3. The attending physician or PCM documents the DD Form 2766 Adult Preventive and Chronic Care Flowsheet, Mar 1998, page 2 of 4, Section 7 (Screening Exams), Item (20).

8.4.2.4. A stamp or hand-written entry noting “Non-FDA licensed blood product transfusion recipient” will be made.

8.4.3. The attending physician or PCM will ensure that the patient will have, whenever possible, pre-transfusion blood specimens collected and submitted for testing to determine base-line serological studies for Hepatitis B and C, Human Immunodeficiency Virus, Human T-Cell Lymphotrophic Virus, Syphilis, and other transfusion transmitted diseases as appropriate. If a pre-transfusion specimen cannot be obtained, a blood sample for serological testing will be collected as soon as possible post transfusion.

8.4.4. Each MTF will establish a process to ensure retesting of these patients at 3 months, 6 months, and 1-year post transfusion. All testing will be completed and documented in the patient’s medical record as soon as practical.

8.4.5. The patient will be given notice, prior to transfusion if feasible or as soon thereafter as possible, that the blood is not FDA licensed, the reasons it is being provided, and the necessary patient follow-up.

8.4.6. These guidelines not only apply to Department of Defense beneficiaries stationed at established overseas bases, but to all deployed personnel in operational theaters to include Reservists and National Guardsmen. Proper follow-up care will continue following demobilization, separation and retirement from military duty.
8.4.7. Each transfusion of a non-FDA licensed blood product will be reported to the appropriate Unified or Specified Command, or Task Force Surgeon’s office, who in turn, will forward data to the Armed Services Blood Program Office (ASBPO) and the appropriate Service Blood Program Office through the Joint Blood Program Office.

Section 8C—Anatomic Pathology Services

8.5. Anatomic Pathology Services

8.5.1. Air Force MTFs shall seek cytologic services through Air Force or DOD cytology centers.

8.5.2. The MTF/CC coordinates with the Armed Forces Institute of Pathology (AFIP) on the use of contracted commercial laboratories for cytopathology services.

8.5.3. All histopathology or cytopathology cases performed by a contracted civilian pathology service and requiring a second opinion are forwarded to AFIP (Armed Force Institute of Pathology, Building 54, 16th Street NW, Washington DC 20306-6000).

8.5.4. Cytology centers shall assist MTFs to develop quality improvement standards for referring cytopathology specimens to commercial laboratories.
Chapter 9

RADIOLOGY AND RADIOLOGIC SERVICES

Section 9A—Radiology Administration

9.1. Filing Hard Copy Radiographs. All medical non-digital (hard copy) radiographs taken in any MTF, or forwarded from other facilities will be filed in AF Form 2700, Radiographic Film Envelope. Dental Radiographs will be handled in accordance with AFI 47-101, Managing Air Force Dental Services.

9.2. Radiology Technicians

9.2.1. Must complete a locally developed, formal, documented, skill-verification training program before administering intravenous contrast media. This will be documented in the 6-part Education and Training folder.

9.2.2. After appropriate training, technicians may inject contrast media only under the direction of a physician who is immediately available.

9.2.3. The person responsible for the injection, who may be a technologist or registered nurse, must be aware of the signs and symptoms of an adverse effect and must monitor the patient for the development of these signs and symptoms during the examination. The supervising physician, or his or her physician designee, must be immediately available to respond promptly to an adverse effect.


9.3.1. Written Requests: Early interpretation is required when the requesting provider annotates “Wet Reading” on the SF 519B, Radiologic Consultation Request/Report.

9.3.2. Electronic Requests: Early interpretation is required when the requesting provider annotates “Wet Reading” in the information field in CHCS, or when the priority for the study is classified as “stat (immediate),” “ASAP (as soon as possible),” or “notify.”

9.3.3. The radiologist providing early interpretation must contact the referring provider, or an appropriate representative, by phone, electronically, in person, or by handwritten memorandum, and the notification shall be documented in the final radiological report.

9.3.4. Unexpected and serious abnormalities must also be reported to the requesting provider as soon as possible after identification by the radiologist. This notification shall be documented in the final radiological report.

9.4. Completion of Reports

9.4.1. The final report is considered to be the definitive means of communicating the results of an imaging examination to the referring physician. The timeliness of reporting any radiological examination varies with the nature and urgency of the clinical problem. However, the final typed reports shall be completed and available to the referring physician within three working days from completion of the examination in facilities with full-time military or civilian radiologists. In all other facilities, executive management ensures that the radiologist’s reports are typed and available as soon as possible.
9.5. **Film Loaning and Transfer**

9.5.1. Films, or copies of original films may be temporarily or permanently loaned to another MTF.

9.5.2. Personnel at the originating facility maintain AF Form 614, **Charge Out Record**, in place of the original file film envelope. Electronic charge-out processes are also acceptable.

9.5.3. If the film file is permanently transferred to another medical facility, personnel retire the original envelope or AF Form 614, with any film files being retired that year.

9.5.4. Films may be hand-carried by the patient by order of the attending provider.

9.5.5. Patients may hand-carry mammography films, have them sent to a new facility, or request that they be forwarded after the patient’s arrival at the new MTF, IAW para 4.2.6.

9.6. **Contract Employees’ X-Ray Films**

9.6.1. X-Rays taken of contract employees during their period of employment or as part of their termination examinations become part of the employment records, as stated in the employment agreement.
Chapter 10

PHARMACY SERVICES

Section 10A—Pharmacy Services

10.1. Organization

10.1.1. The MTF/CC ensures that the pharmacy operates under the supervision of a pharmacist IAW federal laws, DOD and Air Force policy, and accepted standards of practice as defined by JCAHO, The American Society of Health-Systems Pharmacists (ASHP), The American Pharmacists Association (APhA) and The United States Pharmacopoeia. EXCEPTION: A designated medical corps officer may supervise a pharmacy as a “pharmacy officer” when a pharmacist is not available. The designated officer must follow the same standards as would a pharmacist in carrying out the duties of “pharmacy officer,” including review of inpatient orders and prescriptions for accuracy and completeness.

10.1.2. Pharmacists or designated pharmacy officers provide direct supervision of pharmacy technicians.

Section 10B—Policies and Procedures

10.2. Policies and Procedures

10.2.1. Pharmacies must develop policies and procedures, which provide:

10.2.1.1. Pharmaceutical care consistent with the facility’s scope of care and patient needs.

10.2.1.2. Security measures to prevent the loss of pharmacy stock and unauthorized entry into the pharmacy.

10.2.1.3. A perpetual inventory of Schedule II, III, IV and V drugs.

10.2.2. The Pharmacy Flight Commander, Pharmacy Officer or Element Chief supervises drug storage and preparation areas throughout the MTF and satellite pharmacy operations.

10.2.3. Pharmacies honor prescriptions from:

10.2.3.1. Privileged providers of the Uniformed Services, as described in AFI 44-119, and their civilian counterparts.

10.2.3.2. Veterinarians of the Uniformed Services.

10.2.3.3. Privileged providers of consulting referral military facilities.

10.2.3.4. Providers who are not employees of the United States government must be duly licensed by the jurisdiction in which the MTF is located.

10.2.4. Providers may not prescribe medications listed on the controlled substances list for themselves or for their family members.

10.2.5. Providers may not prescribe medications for themselves. Providers who prescribe medications not on the controlled substances list for their family members must ensure that an evaluation and documentation of that evaluation is placed in the family member’s health record.
10.2.6. Pharmacies shall use policies and procedures adopted by the Pharmacy and Therapeutics function of the medical staff and approved by the MTF/CC.

10.2.7. Pharmacies shall publish a revised formulary at least annually, either in written or digital form, which is readily available to all medical staff.

10.3. Patient Counseling

10.3.1. Pharmacists and trained pharmacy technicians shall offer to counsel patients regarding drug therapy in general, and their newly prescribed medications in particular.

Section 10C—Medication Dispensing

10.4. Medication Dispensing

10.4.1. Pharmacies procure, dispense, recommend or use only drugs approved by the Food and Drug Administration (FDA). EXCEPTION: Pharmacies may dispense approved investigational drugs used in a clinical project using guidelines in AFI 40-402, Protection of Human Subjects in Biomedical and Behavioral Research and when US Presidential waiver authority precludes the need to obtain individual service member consent to receive investigational drug(s) IAW 10United States Code (USC)1107 and 21CFR50.23(d).

10.4.1.1. The pharmacy is the primary area for dispensing medications during normal operating hours. Exceptions and after hours dispensing must comply with all applicable pharmacy practice standards. Dispensing is defined as the provision of medication(s) to a patient, for self-administration, during the course of a patient visit. Samples obtained from pharmaceutical representatives are not to be dispensed by providers. Also refer to paragraph 10.23. for clarification on issuance of Force Health Protection Prescription Products.

10.4.1.2. Pharmacists review all pharmaceutical orders occurring after normal duty hours and ensure that the dispensed medications are annotated in the automated patient profile.

10.4.1.3. Providers dispensing medications outside of the pharmacy, i.e. after-hours clinics, annotate the medication dispensed on the patient’s SF 600, or SF 603, Health Record-Dental, SF 858, Emergency Care and Treatment, or in the electronic medical record. Also see paragraph 10.23., Force Health Protection Prescription Products.

10.4.2. Patients may authorize adult third parties to pick up their prescriptions. An individual acting as the patient’s representative can pick up a prescription for the patient under the following circumstances.

10.4.2.1. The patient has identified, either verbally or in writing, a family member, other relative, personal friend or any other person authorized to pick up prescriptions, or

10.4.2.2. If the patient is not present to give consent, the health care provider may use professional judgment to determine if it is in that patient’s best interest to provide the prescription to the patient’s representative.

10.4.2.3. HIPAA regulations also permit the conveyance of limited protected health information to the patient’s representative. For instance, the pharmacist may explain to the representative that a medication shall be taken on an empty stomach, but shall not disclose that a medication is for the treatment of a particular condition.
10.4.3. Dispensing to inpatient/institutional care facilities outside the MTF is not authorized. Inpatient and institutional care facilities must have pharmacy services available. The MTF is not able to meet labeling and packaging requirements for other facilities. This does not apply to mutual aid situations on the discretion of the Pharmacy Officer and MDG/CC.

10.4.4. Pharmacies may not curtail or withdraw civilian prescription service, nor restrict formulary drugs to any beneficiary class, regardless of the source of the prescription. **NOTE:** Limiting drug availability to specific patients is acceptable when the limitations are based on clinical considerations, such as efficacy and/or potential toxicity. Such limitations shall be accomplished using published disease management guidelines, or those developed cooperatively between members of the medical staff and the pharmacy.

10.4.5. Over-the-counter medication handout programs are not authorized. Over-the-counter medications may be included on the formulary when the Pharmacy and Therapeutics Function determines them to be cost-effective alternatives to prescription products. These drugs will then be prescribed through CHCS and dispensed through the pharmacy.

Section 10D—Formulary Management

10.5. Bulk prescriptions

10.5.1. Pharmacies fill prescriptions or bulk-drug requests upon request. Local policy may allow the bulk prescriptions to be filled when the patient presents to pick-up the prescription.

10.6. Use of Formulary Drugs and Non-Formulary Requests

10.6.1. The pharmacy maintains a formulary that lists drugs and pharmaceutical preparations approved for prescription by the Pharmacy and Therapeutics Function, and/or by the Pharmacoeconomic Center basic core formulary list.

10.6.2. Pharmacies and prescribing providers must use formulary drugs wherever possible. The drugs in the therapeutic classes represented on the DOD Basic Core Formulary (BCF) must be the first line agents at all MTFs. The MTF may supplement therapeutic classes on the BCF with other second line agents to meet patient needs. The MTF may include drugs on their formularies in therapeutic classes not represented on the BCF.

10.6.3. Pharmacies need not honor prescriptions from non-referral medical facilities for drugs not on the formulary. If an active duty member requires a non-formulary prescription, the primary care manager (PCM) must annotate the DD Form 2081, New Drug Request or an equivalent form. The MTF will have a written policy for requesting, processing and filling non-formulary drugs. Pharmacies may provide drugs not included in the MTF formulary. The MDG/CC will designate who may approve or disapprove requests for non-formulary drugs dispensed from the MTF pharmacy. The Pharmacy and Therapeutics Function will review all non-formulary approvals at each meeting. Frequent requests for a non-formulary drug shall prompt consideration for addition to the MTF formulary.

10.6.4. The pharmacy will have a written policy for filling non-formulary requests. If a designee is used for non-formulary approval, the pharmacy will submit a signed summary of non-formulary approvals from the MDG/CC to the Pharmacy and Therapeutics Function at each meeting. Before pharmacies purchase the drug for stock, the Pharmacy and Therapeutics Function evaluates it for possible addition to the formulary.
10.6.5. Prescriptions from referral facilities, for medications not on the formulary are dealt with the same as for MTFs. Referral MTF’s must provide patients with at least a reasonable supply of medication when recommending long-term therapy, to allow the local MTF time to procure the non-formulary medication. Referral from civilian facilities may require purchase in a civilian pharmacy until the prescription can be obtained by the MTF.

10.7. Air Force High Dollar Drug Program

10.7.1. The local MTF arranges for or provides medications to treat conditions such as immunodeficiency diseases, transplants and other rare conditions. NOTE: In situations in which the cost to the MTF exceeds $500 per patient per month, the Air Force High Dollar Drug Program at Wright-Patterson AFB shall be utilized.

10.8. Generic Medication

10.8.1. Pharmacies may fill prescriptions written by DOD providers for brand-name drugs with an FDA approved generic equivalent when available.

10.8.2. Pharmacies must fill prescriptions for formulary drugs written by civilian providers for eligible beneficiaries. Substitution of generic for brand-name products on prescriptions from non-MTF providers follows applicable state pharmacy practice guidelines. Pharmacies will not special purchase brand-name drugs to fill civilian prescriptions.

Section 10E—Pharmacy and Therapeutics Function

10.9. The Pharmacy and Therapeutics Function

10.9.1. This medical staff function must meet at least four times per year. It must have at least six members, including two physicians, one dentist, one pharmacist (if assigned), the chief of medical logistics management (or designee), and one nurse.

10.9.2. Other interested personnel whose attendance can improve the function shall be included.

10.9.3. Functions include:

10.9.3.1. Review of policies, acquisition, and use of drugs within the MTF and at remote sites for the Independent Duty Medical Technicians (IDMTs).

10.9.3.2. Review of medication errors for clinical improvement and patient safety opportunities.

10.9.3.3. Review of adverse reactions to drugs.

10.9.3.4. Evaluation of clinical data on new drugs and preparations requested for MTF use.

10.9.3.5. The Medical Logistics Officer will quarterly report results of National Contract Compliance Reports and results of the Best Pharmacy Report analysis. Pharmacy and logistics will make recommendations based upon the reviews to the Pharmacy and Therapeutics Committee and report results to MDG/CC, as appropriate

Section 10F—Drug Inventory

10.10. Drug Inventory
10.10.1. The MTF will:

10.10.1.1. Maintain controlled substances according to state and federal regulations.

10.10.1.2. Conduct a complete and accurate inventory of all controlled substances every two years on 1 May (or the first duty day thereafter) of odd-numbered years.

10.10.2. Schedule II drugs will be inventoried separately from Schedule III, IV and V drugs.

10.10.3. The pharmacy will maintain the files of inpatient unit and clinic inventories.

10.10.4. Pharmacies in coordination/collaboration with logistics will comply with DOD/Veterans Affairs (VA) contracting efforts by aligning all pharmaceutical purchases with the National Contract List posted on the Defense Supply Center Philadelphia (DSCP) website at: https://dmmonline.dscp.dla.mil/pharm/pharmhome.asp. Actions will include at least the following:

10.10.4.1. Review the National Contract List (NCL) at least monthly.

10.10.4.2. Develop a process to identify and track products on pharmacy shelves that are on the NCL. Update monthly as necessary.

10.10.4.3. Use the National Contracts Compliance Reports (NCCR) to expedite identification of contract non-compliance. NCCR is available through the DSCP website at: http://dmmonline.dscp.dla.mil/nationalcontracts/nccrhome.aspx. NOTE: Access to NCCR requires user name and password that can be acquired through DMM on-line registration.

10.10.4.4. Develop a process to identify and track contracted products on manufacturer back order status to ensure prompt return to mandatory sources upon release.

10.10.4.5. Coordinate with Medical Logistics to ensure MEDLOG and DMLSS are regularly updated to reflect contracted products and prices.

10.10.4.6. Document results of the NCCR and NCL review for quarterly presentation to the Pharmacy and Therapeutics Function.

10.10.4.7. IAW with AFI 41-209, pharmacy and medical logistics personnel will perform a Pharmacy Price Analysis (PPA) on noncontracted pharmaceuticals on a quarterly basis.

10.10.4.8. Pharmacy personnel request this report at: https://dmmonline.dscp.dla.mil/login/ct_logon.asp?CTAuthMode=BASIC&language=en

10.10.4.9. Pharmacy personnel will review the report and identify equivalent products with potential savings.

10.10.4.10. Coordinate with Medical Logistics to ensure MEDLOG and DMLSS are updated to reflect products from Best Pharmacy Reports. Document results of the PPA for quarterly presentation to the Pharmacy and Therapeutics Function.

10.11. Controlled Drug Inventory Process

10.11.1. The MTF Commander appoints a disinterested officer, a member of one of the top three non-commissioned officer (NCO) grades, or a civilian of comparable grade to inventory the Schedule II controlled drugs at least monthly. Personnel conduct the inventory in the facility’s pharmacy and in all other locations where Schedule II controlled substances are maintained, including the veterinary clinic.
10.11.1. Facilities inventory newly controlled substances on the published effective date. Thereafter, each substance will be included in the biennial inventory.

10.11.2. Inventory personnel adjust shortages and overages on the AF Form 85A. The AF Form 85A is reviewed by the Pharmacy Flight and Squadron Commanders. The final approval authority for the AF Form 85A is the MTF Commander. The MTF Commander may delegate this authority by appointing a designee in writing for medications in Schedule Classes III-V but must retain authority for all Schedule Class II medications.

10.11.3. Inventory personnel record the balance on each AF 582, Pharmacy Stock Record, or automated product (spreadsheet, database or work processing reports) and AF Form 579, including the date of inspection, action taken, and signature.

10.12. Accountability of Controlled Substances

10.12.1. Pharmacists use AF Form 582 or an automated product if maintained in a perpetual inventory, for each item to show all receipts and expenditures of Schedule II, III, IV and V drugs including:

10.12.1.1. Ethyl alcohol

10.12.1.2. Alcoholic beverages used for medicinal purposes (wine, whiskey, beer, etc.)

10.12.1.3. Other drugs designated for control by the MTF Pharmacy and Therapeutics Function.

10.12.2. Accounts for all AF Form 579:

10.12.2.1. Issues a new, serially numbered AF Form 579 to inpatient units and clinics as needed.

10.12.2.2. Brings forward the balance and serial number from the previous sheet.

10.12.2.3. Accepts and maintains all completed forms.

10.12.2.4. Initiates a new series of forms each calendar year after collecting all incomplete forms from the previous year.

10.12.2.5. Uses automated methods to account for AF Forms 579 whenever possible.

10.12.2.6. Pharmacists coordinate with Medical Logistics to ensure 21 CFR reporting requirements are met in the event of any unusual or excessive loss or disappearance of controlled substances from the pharmacy, inpatient units, outpatient clinics or any location to which the pharmacy distributes. Pharmacists must:

10.12.2.6.1. Notify their chain of command prior to filing the report of loss.

10.12.2.6.2. Notify Security Force and/or the Office of Special Investigations if theft is suspected. NOTE: Reporting forms may be found on the DEA website at: [http://www.deadiversion.usdoj.gov/21cfr_reports/index.html](http://www.deadiversion.usdoj.gov/21cfr_reports/index.html)

10.13. Securing Drugs

10.13.1. MTF personnel secure all controlled and non-controlled drugs. Local policy will determine which categories of personnel may be permitted to secure non-controlled drugs or to carry keys to secure areas. With the exception of authorized pharmacy personnel, only licensed clinical staff may be authorized access to controlled substances storage areas.
10.13.2. In the pharmacy, personnel store Schedule II, III, IV, and V controlled drugs in either a safe or securely locked, substantially constructed cabinet, as described in 21 CFR 1301.75. A small working stock of Schedule II, III, IV and V controlled drugs may be kept in the main dispensing area. Each drug must be inventoried at the beginning of each shift or at shift change by reconciling the prescription quantities dispensed with the balance on hand.

10.13.2.1. All discrepancies will be documented on an AF Form 85A, which is submitted to the MTF Commander (or designee) through the chain of command, for review and approval.

10.13.3. Pharmacists may dispense Schedule II, III, IV, and V controlled drugs from automated dispensing equipment that meets the following requirements:

10.13.3.1. Equipment must store counted product in an internal chamber that requires scanning of a bar-code to dispense.

10.13.3.2. Equipment requires unique user login password prior to accessing any product.

10.13.3.3. Equipment’s bulk holding chamber is secured with locking device.

10.13.3.4. Equipment must store bulk product in a removable cassette or cell.

10.13.3.5. Equipment must maintain a perpetual inventory of each removable cassette or cell.

10.13.4. All prescriptions for Schedule III, IV, and V controlled drugs dispensed from automated equipment must be double-counted either by hand or using a device that determines the quantity based upon the product’s weight.

10.13.5. Pharmacies dispensing Schedule III, IV, and V controlled drugs from automated equipment must also meet the following security requirements:

10.13.5.1. Removable cassettes or cells containing controlled drugs must be removed from the equipment and secured in the pharmacy’s safe or securely locked, substantially constructed cabinet at the end of each duty day.

10.13.5.2. Cassettes or cells containing controlled drug must be completely emptied and counted at least once every 3 business days. Quantities of controlled drugs in cassettes or cells may be obtained from the equipment’s perpetual inventory for controlled drug inventories on the remaining 2 days.

10.13.6. Schedule II drugs must be stored in a substantial double-locked cabinet in patient areas outside the pharmacy. All other controlled substances must be stored in a secure, locked cabinet. Access is restricted to those individuals authorized to prepare, administer or dispense controlled substances.

Section 10G—Writing Prescriptions

10.14. Writing Prescriptions

10.14.1. Authorized providers must:


10.14.1.3. Use AF Form 781, Multiple Item Prescription, if not using electronic order entry.

10.14.1.4. Write no more than 3 prescriptions on AF Form 781.
10.14.1.5. Draw a line through unused blocks on AF Form 781.

10.14.1.6. Separate prescriptions for drugs listed in Schedules II, from those in Schedules III, IV, and V by writing them on separate AF Forms 781.

10.14.1.7. Non-controlled drugs may not be prescribed on the same form as controlled drugs.

10.14.1.8. Write-in complete patient identification data on AF Form 781 (name, address and patient identification number).

10.14.1.9. The prescriber name stamp must be used on all hand-written prescriptions. If a prescriber name stamp is not available, then the prescriber shall write full name, rank, corps, AFSC, and telephone number. The pharmacy may decline to fill such a prescription, if there is any uncertainty as to the identity of the prescriber.

10.14.1.10. The prescribed amounts of controlled substances will be spelled out in addition to the written numeral amount.

10.14.1.11. DEA numbers shall be used on any hand-written prescriptions for Controlled Substances. Non-US physicians and dentists assigned to overseas facilities use medical or dental license numbers instead of a DEA number.

10.14.2. Providers may not write controlled substances prescriptions, including drugs controlled locally (at the MTF level) for themselves or members of their families.

10.14.3. The prescribing provider and the pharmacist are equally responsible for correctly prescribing and dispensing controlled substances (Schedules II, III, IV, and V) under Title 21, U.S.C., sections 829 and 1309, concerning Prescribing and Dispensing Controlled Substances.

10.14.4. The prescribing provider signs prescriptions or documents them via CHCS electronic signature and dates them on the day of issue.

10.14.5. Prescriptions for chronic maintenance medications may be written for up to a 90-day supply. Non-chronic medications are written for an adequate quantity to treat the acute problem, as deemed by the provider. In most instances, these will not exceed a 30-day supply.

10.14.6. Where feasible, the pharmacist contacts the prescriber to resolve problems of legibility, compatibility, dosage or quantity prescribed. The pharmacist verifies authenticity of prescriptions and may refuse to fill prescriptions that contain errors, omissions, irregularities, ambiguity, alterations or are contrary to the pharmacist’s clinical judgment.

10.14.7. Pharmacies may accept faxed prescriptions for noncontrolled substances and controlled substances in Schedules III-V from provider’s offices, hospitals or nursing homes in keeping with applicable state and federal laws.

10.14.8. When a provider prescribes a medication, controlled substance or otherwise, for another provider, a decision must be made by the prescriber concerning how that medication may affect the patient’s ability to practice medicine. A Quarters Form or an AF Form 422 must be annotated with a copy to the Chief of the Medical Staff, if the medication is expected to impair a provider’s ability to practice medicine. An annotation will be made on the SF600 by the prescribed that the prescribed medication is or is not expected to affect the providers-patient’s ability to practice medicine.

Section 10H—Packaging Prescriptions
10.15. Packaging Prescriptions


10.15.2. When issuing prepackaged medications to clinics for outpatient dispensing by providers, include a label for the patient’s name, patient education material, and directions for use with every container.

10.15.3. Prepackaged medications dispensed by a provider directly to the patient do not require prescriptions. Note the prescribed treatment on the SF 600, or SF 603. Dispensing outside the pharmacy is limited to providers whose license allows dispensing directly to patients, generally dentists and physicians. Providers must adhere to the same procedures and standards of practice as apply to dispensing from a pharmacy to ensure a single standard of care.

10.15.4. Manufacturer samples may not be kept in the MTF or dispensed to patient.

10.15.5. Medications procured for the purposes of clinical investigation are dispensed only from the pharmacy according to an Institutional Review Board approved protocol. The process for participation in clinical investigations is outlined in AFI 40-402.

10.16. Labeling Prescriptions

10.16.1. Only pharmacy personnel are authorized to label and transfer medications from the manufacturers’ package to different containers.

10.16.2. Prepare a label for each prescription and fasten it securely to each package or container before dispensing. The label must conform to requirements stated in the Food, Drug, and Cosmetic Act, Sections 502 and 503 and 21 U.S.C. Sections 352 and 353. Give the patient additional information when necessary to ensure that they use and store the drugs properly.

10.17. Refilling Prescriptions

10.17.1. The provider authorizes a pharmacy to refill certain prescriptions by giving refill information to the original prescription.

10.17.2. Pharmacies may not refill prescriptions for drugs listed in Schedule II. Pharmacies may not refill prescriptions for drugs listed in Scheduled III, IV, and V more than six months after the date of issue or more than five times total.

10.17.3. Pharmacies normally honor prescription refills only if they have the original prescription on file. Pharmacists may request transfer of an original prescription provided that the validity of the prescription (e.g., that refills are available and the prescription is still active, etc.) is verified with the pharmacist at the transferring facility before filling the prescription. The transferring facility will discontinue the original prescription and note in the comment field of CHCS the name of the pharmacist, the facility and the date transferred. The receiving facility must ensure their database reflects the original fill date, prescription number, provider name and DEA number and the adjusted number of refills remaining. Prescriptions for controlled medications may be transferred once, while prescriptions for non-controlled prescriptions may be transferred more than once as necessary for patient needs. Transferring prescriptions shall follow federal law and where possible, local state pharmacy regulations.
10.17.4. Prescriptions may be refilled when 75% of the quantity dispensed has been used by the patient, based on the directions for use and the quantity prescribed. Early refills are generally not authorized.

10.18. Mailing Medications

10.18.1. Under usual circumstances, routine mailing of prescriptions to eligible beneficiaries by MTF pharmacies is not authorized.

10.18.2. Prescriptions may be mailed to patients enrolled at or routinely receiving care at an MTF in an emergency or when personal hardship/disability keeps them from leaving their homes. Follow postal service regulations for mailing controlled substances.

10.18.3. Encourage patients requesting mail order pharmacy services to enroll in TRICARE Prime and to utilize the contract TRICARE Pharmacy program.

10.19. Use of Pharmacy Automation Equipment (refer to paragraph 10.13.3. also)

10.19.1. Pharmacy automation equipment will be used to the maximum extent possible in the dispensing of outpatient prescriptions. In the event of a power outage or equipment malfunction, pharmacies must have appropriate downtime procedures to maintain accuracy in the dispensing process.

10.19.2. Pharmacists will ensure that safety features designed into automation equipment are being used and access to safety overrides is limited.

10.19.3. Every manufacturer package intended for stock in automated dispensing equipment will be barcode scanned and logged in at the time it is placed into the equipment. Unclaimed prescriptions that are returned to stock must also be barcode scanned prior to being loaded into equipment.

Section 10I—Inpatient Pharmacy Services

10.20. Inpatient Pharmacy Services

10.20.1. The Pharmacy Flight Commander or Element Chief:

10.20.1.1. Determines the extent of services based on available staff, funding and workload. Any changes in services that will affect pharmacy operating hours must be coordinated with the Squadron and MTF/CC.

10.20.1.2. Develops a priority order of services provided as available resources change.

10.20.1.3. Ensures that a pharmacist reviews all inpatient orders.

10.20.2. Unit Dose Drug Distribution will be used to the maximum extent possible. This system provides inpatient drugs under a direct copy of AF Form 3066, or an approved electronic order. A patient medication profile must be maintained on AF Form 3069, Medication Administration Record or an automated product.

10.21. Sterile Product Preparation

10.21.1. A pharmacist supervises the preparation of intravenous admixtures by pharmacy staff and ensures non-pharmacy personnel preparing admixtures outside of the pharmacy are trained to follow
the United States Pharmacopoeia Chapter 797 Standards (USP 797) for the preparation of sterile products.

10.21.2. Pharmacies providing sterile products will implement and document the following programs:

10.21.2.1. Personnel training and evaluation in aseptic technique and random product sterility testing for each compounded sterile product (CSP) risk level used in the facility.

10.21.2.2. Environmental quality and control monitoring to ensure ISO 5 environment.

10.21.2.3. Education and training of all affected MTF personnel on the handling, storage and transport of CSPs.

10.21.2.4. Patient monitoring and adverse events reporting.

10.21.2.5. CSP quality assurance to continually evaluate and improve the preparation of sterile products.

10.21.2.6. Other programs necessary to meet the intent of USP 797.

10.22. Bulk Compounding

10.22.1. Pharmacists bulk compound pharmaceutical preparations using formulas from official compendia, other references or locally developed formulas only when a quality product can be ensured. Use:

10.22.1.1. AF Form 2381, Pharmacy Master Formula, for each item manufactured in bulk quantities.

10.22.1.2. AF Form 2382, Pharmacy Bulk Compounding Chronological Control Log, to assign lot numbers to each preparation.

10.22.1.3. AF Form 2380, Pharmacy Manufacturing Control Data, for each individual batch prepared.

10.22.1.4. AF Form 781, to account for all controlled drugs used in compounding.

10.23. Issuance of Force Health Protection Prescription Products (FHP PPP)

10.23.1. FHP PPP are defined in HQ USAF/SG policy memo (24 Jun 03), AFMS Policy on Force Health Protection Prescription Products (FHP PPP), and include atropine/2-PAM Chloride/CANA auto-injectors, certain antimicrobials including antimalarials and pyridostigmine bromide.

10.23.2. Issuance of FHP PPP may be accomplished through Medical Logistics or at the pharmacy on a prescription. Issuance of FHP PPP in contingency situations should occur as necessary to support the AF mission.

10.23.3. The medical record and CHCS drug file of all patients issued FHP PPP will be documented with the drug name, strength, quantity, directions and name of ordering provider on an SF600 and on the deploying members DD Form 2766.

10.23.4. Documentation and issuance of Force Health Protection Products is a collaborative effort between Medical Logistics, Pharmacy and Deployment Medicine personnel. The MTF will develop a local policy to establish communication and coordination between departments for this purpose.
Chapter 11

OPTOMETRY SERVICES

11.1. Policies and Procedures

11.1.1. Optometrists

11.1.1.1. Ensure vision, optical and eye health readiness of the forces.

11.1.1.2. Support the flying mission through examining and treating the eyes and vision of air-crew members and by prescribing spectacles, contact lenses and other optical devices.

11.1.1.3. Screen, refer, and provide post-operative care of active duty members participating in the Aviator and Warfighter laser surgery programs.

11.1.2. Using Therapeutic Agents: Optometrists may prescribe drugs for topical ocular therapy and systemic management of ocular disorders, within the scope of practice of their clinical privileges.

11.2. Contact Lens Services

11.2.1. Aviator Contact Lens program has priority over all other contact lens services.

11.2.2. For active duty members with medical conditions that require contact lenses, optometrists may prescribe and issue contact lenses at government expense.

11.2.3. The MTF Commander determines whether to provide cosmetic or elective contact lenses when, for example, unique military or special duty requirements exist.

11.2.4. Patients pay for lenses ordered for cosmetic or elective reasons.

11.3. Documentation of Optometry Services. Use:

11.3.1. AF Form 781, or electronic entry in CHCS when prescribing therapeutic agents.

11.3.2. AF Form 1721, Spectacle Prescription, to provide patients with a prescription that civilian spectacle suppliers may fill.

11.3.3. AF Form 1722, Optometric Examination Record, DD Form 741, Eye Consultation, or an overprinted SF 600, to document routine eye examinations, or in the electronic medical record.

11.3.4. DD Form 771, Eyewear Prescription, when Spectacle Request Transmission System (SRTS) is not available.

11.3.5. SF 88, Report of Medical Examination, for physical examinations.

11.3.6. SF 513, Medical Records Consultation, for documenting referral evaluations or electronic entry in CHCS.

11.3.7. SF 600, for follow-up and urgent care visits, or electronic entry in CHCS.

11.3.8. DD Form 2351, Department of Defense Medical Examination Review Board (DOD-MERB) Report of Medical Examination, for USAF Academy, Reserve officer Training Corps (ROTC), and Uniformed Services University of the Health Sciences (USU) applicants.
Chapter 12

PHYSICAL/OCCUPATIONAL THERAPY SERVICES

12.1. Requests for Occupational and/or Physical Therapy are documented via electronic order entry in CHCS or on AF Form 1535, Physical Therapy Consultation.

   12.1.1. Requests may be written by all privileged MTF providers, other uniformed services providers, and by civilian physicians and dentists.

12.2. Documentation

   12.2.1. Occupational Therapy will document patient evaluation, treatment plans and goals on SF 513, or AF Form 1535. Ongoing therapy can be documented on SF 509, Medical Record-Progress Note; SF 600, or AF Form 1412, Occupational Therapy Treatment Record.

   12.2.2. Physical Therapy will document patient evaluation, treatment plans and goals on SF 513, AF Form 1535, or AF Form 1536, Physical Therapy Consultation, Continuation Sheet.
Chapter 13

BEHAVIORAL HEALTH SERVICES

Section 13A—Continuity of Care and Other Issues for Mental Health Patients

13.1. Initial Evaluations

13.1.1. Life Skills Support Centers must ensure that referred patients who fail to keep their initial life skills appointments are contacted by a member of the Life Skills Support Center and make every effort to reschedule missed appointments with the Life Skills Support Center, as soon as possible. The referring provider must be notified whenever a patient fails to keep their initial appointment. NOTE: Patients on flight status will require a Flight Surgeon to be notified of missed appointment in order to perform a flight safety operational risk assessment.

13.1.2. Each MTF must develop a mechanism to track “high risk” patients. This tracking system shall be designed to discourage these patients from canceling appointments, or failing to keep appointments, without speaking directly to a provider. Such individuals are well suited for case management. Should a patient who is determined to be a “high-risk” fails to keep an appointment or declines to reschedule an appointment the member’s/sponsor’s commander will be notified, along with the appropriate HIPAA documentation accomplished.

13.1.3. Advocacy, ADAPT and Life Skills will ensure that individuals known to be at high risk for lethal or dangerous behavior are identified to appropriate on-call providers and emergency room staff. Appropriate patient confidentiality will be maintained.

13.1.4. After-hours mental health evaluations shall not be performed in places such as the duty section, at the patient’s residence, or after-hours in a closed MTF since medical support and security are not available.

13.2. Follow-up by the Life Skills Support Center

13.2.1. Active duty patients referred to a civilian facility shall have a follow-up plan with a Life Skills provider, in order to facilitate the AF Form 422 annotation. Ideally, the provider can obtain permission from the patient to follow/document medication and restrictions for annotation in the Life Skills record. Patients who self refer to civilian care at their own expense must be tracked by their primary care manager (PCM) at specific intervals to document duty and readiness fitness.

13.2.2. Life Skills Support Centers must ensure that follow-up patients who fail to keep their life skills appointments are contacted by a member of the Life Skills Support Center and make every effort to reschedule missed appointments with personnel assigned to the Life Skills Support Center, as soon as possible. NOTE: Patients on flight status will require a Flight Surgeon to be notified of missed appointment in order to perform a flight safety operational risk assessment.

13.3. Evacuation and Hospitalization. US military commanders in foreign countries may evacuate or hospitalize non-active duty beneficiaries without their consent only after compliance with laws and procedures of the host country or, if applicable, the Status of Forces Agreement with that host country.
13.4. The Repatriate Program of Assistance to Mentally Ill US Citizens/Nationals Returned from Foreign Countries. MTFs may aid patients being repatriated under this program through hospitalization and arrangement of transfer of care to appropriate parties.

13.4.1. Department of Health and Human Services (DHHS) may provide care for nonmilitary patients, including alien dependents of US citizens, when they return to the US (Public Law 86-571, 42 U.S.C. 1313 and 45 CFR 211 and 212).

13.4.2. DHHS may intervene when patients are not releasable to their next of kin and no longer qualify for military hospitalization.

13.4.3. DHHS acts upon request of the Department of State (45 CFR 211, 212).

13.4.4. Overseas commanders must ask local US diplomatic representatives to make arrangements through the Department of State with DHHS for patients returning to the US. NOTE: These instructions do not limit the authority to detain emergency medical cases temporarily pending compliance with the laws of the host government.

Section 13B—Using Clinical Hypnosis

13.5. Provider Privileges: Providers may be granted privileges to administer hypnotherapy within their own field if they meet the recommendations and requirements of the American Society of Clinical Hypnosis or the Society for Clinical and Experimental Hypnosis.

13.5.1. Restrictions

13.5.1.1. Providers may not use hypnosis on individuals on flying status, in the Personnel Reliability Program, or engaged in a Sensitive Duty program.

13.5.1.2. Providers may not use hypnosis or drug-induced interviews on witnesses or victims of crimes, or known subjects of Air Force Office of Special Investigations (AFOSI) investigations. EXCEPTION: These subjects may undergo hypnosis or a drug-induced interview with full coordination from AFOSI and with the individual’s permission prior to hypnosis or drug-induced interview.

13.5.1.3. Chaperones must be present during hypnosis sessions.

Section 13C—Formal Sex Therapy

13.6. Clinician Requirements: Clinicians privileged to provide sex therapy must meet the supervision requirements, or be recognized as a certified sex therapist by the American Association of Sex Educators, Counselors and Therapists.

13.6.1. Chaperones must be present during sex therapy sessions.
Chapter 14
ALLERGY AND IMMUNIZATIONS SERVICES

14.1. Responsibilities:

14.1.1. AF/SG will appoint, in writing, the Chief Consultant for Allergy/Immunizations (A/I).

14.1.2. The Chief Consultant to the AF/SG for Allergy/Immunology, working through AFMOA/SGOC:

14.1.2.1. Organizes MTFs into allergy regions.

14.1.2.2. Designates regional A/I consultants in writing.

14.1.2.3. Determines/approves the content of the Allergy Extender Short Course.

14.1.3. The regional A/I consultants:

14.1.3.1. Establish and monitor the A/I services for each MTF within their region. Assists MTF’s with accomplishing peer review for the providers credentialed in allergy.

14.1.3.2. Provide consultative support to MTF providers within the region.

14.1.3.3. Approve use of allergy extracts not provided by the regional allergy support facility, when appropriate.

14.1.3.4. Coordinate with appropriate MAJCOM SGPM on issues pertaining to immunization related preventive health issues.

14.1.3.5. Visit local MTFs as requested by the MTF.

14.1.3.6. Monitor immunotherapy training program for Allergy Immunotherapy (AIT) personnel (4N05/71 with SEI 453) assigned to their region.

14.1.4. Regional allergy support facilities provide AIT extract kits to the supported MTFs.

14.1.5. 4N0X1 Career Field Manager (CFM) designates an enlisted consultant for A/I and manages SEIs; 453 indicating Allergy and 454 indicating Immunization, for utilization, training and career progression.

14.1.6. The enlisted consultant for A/I:

14.1.6.1. Serves as liaison between AFMOA, SG A/I consultant and MTF A/I services.

14.1.6.2. In concert with 4N0X1 CFM, reviews and updates training requirements in the 4N0X1 Career Field Education and Training Plan and coordinates with the A/I course at Walter Reed Army Medical Center to ensure Air Force training requirements are met.

14.1.6.3. Provides subject-matter expertise on A/I as required. In coordination with the AF Public Health, conducts research and provides updates on new vaccines, immunization schedules and policies.

14.1.7. The MTF/CC designates a trained or experienced physician responsible for the MTF A/I clinic or services. Where a trained allergist is not available, this physician shall be trained as an allergy-extender.
14.1.8. Designated physician responsible for A/I services:

14.1.8.1. Provides the clinical oversight for AIT and immunizations.

14.1.8.2. Acts as consultant for healthcare providers for policy and questions/concerns for patient care related to AIT and immunizations.

14.1.8.3. Approves the clinic’s budget and operating instructions.

14.1.8.4. Utilizes applicable AFMOA or MAJCOM guidance in conjunction with Advisory Committee on Immunizations Practices (ACIP) guidelines in establishing directives (standing orders) for vaccine delivery. These directives will be utilized for paraprofessionals delivering vaccines in the absence of the credentialed provider’s written order.

14.1.9. MTF Public Health Officer

14.1.9.1. Sits on the Population Health Working Group and provides guidance on vaccine schedules/policies and acts as consultant to healthcare providers for policy and questions/concerns on immunizations.

14.1.9.2. Serves as the primary POC for notifying installation commanders of the medically ready to deploy status of their troops.

14.1.9.3. Provides guidance on required immunizations for deployments.

14.2. Training for Allergy Immunotherapy (AIT) Personnel

14.2.1. The non-allergist physician designated to provide MTF-level A/I oversight must complete the Allergy Extender Short Course at the 59th Medical Wing, Lackland AFB, TX and attend a one-week orientation with the regional allergy consultant to obtain clinical experience.

14.2.2. Nurses who provide immunotherapy injections must complete training from the supervising allergist, designated provider.

14.2.3. 4N0X1S Technicians will complete introductory training via the J5ALA4N031A, Allergy Immunization Technician Course at Walter Reed Army Medical Center. Only those enlisted individuals who complete this course will be authorized to provide immunotherapy to patients.

14.2.4. All enlisted personnel providing immunotherapy (except those assigned to a regional allergy center) must attend refresher training of five days duration every two years, to update on immunotherapy practices. In most cases, the refresher training will be conducted at a regional facility. The biennial AIT refresher training is funded by the MTF where the trainee is assigned.

14.2.5. Immunization Augmentee Program. This program has two components. The Immunization Back-up Technicians (IBTs) provide back-up coverage in the immunization clinic, point of service immunization in the clinic setting and support of mobility processing lines. The Immunization Augmentees (IAs) provide assistance during times of mass immunizations such as influenza. Neither the IBT nor IA may provide immunotherapy (allergy shots) for patients. Physicians, Physician Assistants and Nurses are excluded from the requirements of these paragraphs.

14.2.5.1. IBTs shall be at least a 4N051 or a civilian Licensed Practical Nurse (LPN) whose state nursing license allows the administration of immunizations. 4N031 can be IBTs if they have completed their Career Development Courses (CDCs) and have the recommendation of the MTFs senior 4N0.
14.2.5.2. IAs may hold any 4XXXX AFSC. Medical AFSCs other than 4N0 must have a scope of practice waiver on file to perform duties outside their AFSC.

14.2.5.3. Initial Required Training

14.2.5.3.1. IBTs must complete the IBT Distance Learning Course within 90 days of receipt of IBT study guide and must pass the end of course exam with at least a 70%. NOTE: Individuals failing the written test will be tutored by a 4N0X1 SEI 454 (or to be determined by ANG/AFRC) before any retests.

14.2.5.3.1.1. For pediatric immunizations, complete a minimum of 10-duty days providing pediatric immunizations/documentation and demonstrate proficiency. (NOTE: Upon successful completion of QTPs and demonstrated proficiency, the timeframe required may be reduced at the recommendation of the 4N0X1 (SEI 454) or supervising nurse and with the concurrence of the MTF senior 4N0).

14.2.5.3.1.2. For adult immunizations, complete a minimum of 5-duty days providing adult immunizations/documentation and demonstrate proficiency. (NOTE: Upon successful completion of QTPs and demonstrated proficiency, the timeframe required may be reduced at the recommendation of the 4N0X1 (SEI 454) or supervising nurse and with the concurrence of the MTF senior 4N0).

14.2.5.3.2. Immunization Augmentee (IA) trainees will complete just-in-time training to include a briefing on vaccine package insert information, anaphylaxis and local emergency response protocols. Training will be reaccomplished if more than 90 days have elapsed since administering any vaccine or if a different vaccine is to be administered.

14.2.5.3.3. Units Education/Staff Development will play a key role in administering and safeguarding the IBT Exam. They will be responsible for informing supervisors of any failures and also administering re-test. (After third failure, Supervisor/Commander will take appropriate actions.)


14.2.6.1. IBTs will complete a minimum of six hours performing IBT duties and a minimum of two hours immunization continuing education every quarter. The continuing education shall include, but is not limited to, in-services, training time spent with a 4N0X1S, record reviews or performing immunizations at point-of-service locations. Annually, the IBTs will complete all applicable 4N0X1A Immunization Qualification Training Packages. EXCEPTION: MAJCOM’s 4N0X1 Functional Managers will determine how 4N0X1Cs at deployed/remote locations maintain proficiency to comply with the intent of instruction.

14.2.6.2. IBTs that do not complete quarterly training will have to spend 5 days of duties under the direct supervision of a 4N0X1 SEI 454 to meet the elapsed training.

14.2.6.3. IBTs that miss three consecutive quarters will have to restart the whole IBT training process discussed under initial training.

14.3. Quality Assurance: The Immunization physician director, MTF senior 4N0 and the 4N0X1 SEI 454 are responsible for oversight of the IBT program. MTF Senior 4N0 will provide oversight of immunization activities to include training, documentation, sustainment and utilization of the A/I techs, IBTs and IAs IAW AFI 46-101. Responsibilities include, but are not limited to:
14.3.1. Ensuring integrity and quality of initial/sustainment training

14.3.1.1. Randomly evaluate the training provided by the fully qualified IBTs.

14.3.1.2. At a minimum, 10% of the new IBTs will be certified by the 4N0X1 SEI 454.

14.3.1.2.1. Ensures patient care standards are met.

14.3.1.2.2. Ensures proper management/storage of all vaccines.

14.3.1.3. Perform Record reviews

14.3.1.3.1. Complete a random quarterly medical records review for immunizations given by IBTs.

14.3.1.3.2. The review will consist of at least the following: DD 2766C; documentation that the Vaccine Information Sheet (VIS) was provided to patient/guardian; data entry in Air Force Complete Immunization Tracking Application (AFCITA).

14.3.1.3.3. Report and manage all immunization-related incidents.

14.4. Allergy Clinic and AIT Administrative Issues

14.4.1. Point of Service. Point of service for immunizations provides patients with required immunizations at primary care clinics, such as pediatrics, internal medicine, family practice or flight medicine clinics. Where point of service immunizations are provided, the facility must have a written plan for the storage and monitoring of vaccines.

14.4.2. Documentation of Immunizations. Immunizations will be documented in the Air Force Complete Immunizations Tracking Application (AFCITA) program. Individuals entering data into AFCITA must complete the AFCITA training. Documentation will be IAW AFJI 48-110.

14.4.3. Administration of Civilian Allergy Extracts. Civilian AIT extracts will be administered by the civilian provider who prescribed the extract. EXCEPTIONS: Members on TDY status and activated Guard and Reserve personnel may receive civilian-prescribed AIT at an MTF if all the following criteria are met: the time-frame of the TDY or the activation is less than one year; the civilian extract must be labeled with the patient’s name and unique identifier, the extract contents, the extract dilution and the expiration date of the extract; the extract must be accompanied with a copy of the civilian providers notes concerning the extract, to include the schedule of administration; the extract administration must be approved by the military regional allergy consultant.
Chapter 15

AUDIOLOGY SERVICES

15.1. Diagnostic Hearing Centers (DHC)

15.1.1. The Air Force provides hearing aids, replacement parts, accessories, batteries and repair services at no cost to active duty members of the Uniformed Services at the DHCs. Retired members of the Uniformed Services may, on a space available basis, obtain hearing aids at no cost if MTF resources permit. If resources do not permit, the Retiree Hearing Aid Purchase Program may be used, if available, at the MTF.

15.1.2. Only DHCs are authorized to purchase, prescribe, fit and issue hearing aids. All DHCs establish a reliable source of hearing aids and hearing aid supplies through US General Services Administration (GSA) contractors or Blanket Purchase Agreements with the Defense Supply Center Philadelphia or hearing aid manufacturers on a competitive basis.

15.1.3. Contact Hearing Conservation Data Registry at Brook City-Base, TX for current DHC locations.

15.1.4. DHCs issue replacement or reissue hearing aids when the member has orders for either mobility status or a permanent change of station to a remote overseas location.

15.1.4.1. The MTF/CC where member is enrolled sends the request for replacement or reissue hearing aids to the nearest Air Force DHC, or to the DHC that initially tested the member’s hearing and prescribed the hearing aids.

15.1.4.2. The request must include a copy of the member’s orders and mailing instructions.

15.1.5. Active duty members who need binaural amplification, may receive a backup hearing aid when the consulting audiologist approves.

15.1.6. The clinical audiologist bases issuance of monaural or binaural hearing aids on the patient’s need, audiological test results, and medical evaluation and clearance.

15.2. Accessories, Spare Parts, Batteries

15.2.1. The Air Force provides accessories based on the type of hearing aid issued. These could include:

15.2.1.1. Earmolds (one for each ear for which a hearing aid was issued; exceptions can be made by the issuing audiologist).

15.2.1.2. A 60 day supply of batteries. **NOTE:** Issue replacement batteries at no charge to patients for the life of the government issued hearing aid. MTFs without a DHC issue batteries through the pharmacy or medical logistics. Batteries for non-government issued hearing aids are not authorized.

15.2.2. DHCs buy spare parts from manufacturers using local-purchase procedures. These parts may include connecting cords, receivers and rigid tubing.

15.2.3. The DHC prepares a letter for each government-issued hearing aid. It establishes the authority for the recipient to obtain replacement batteries for the life of the hearing aid.
15.3. Repair of Defective Hearing Aids

15.3.1. Hearing aid repairs are only authorized for government issued hearing aids. While under manufacturer’s warranty, the member or the DHC returns the hearing aid to the manufacturer, with a letter explaining the malfunctions.

15.3.2. After the manufacturer’s warranty expires, the patient returns the broken hearing aid and a copy of the issue letter to a DHC. Include a letter explaining the problem. **NOTE:** The DHC will send the hearing aid to a contract repair facility.

15.3.3. Patients returning a government issued hearing aid for repair may receive a hearing aid on loan if available. **NOTE:** DHCs may maintain a small stock of loaner hearing aids.

15.3.4. The MTF/CC may authorize rental of a hearing aid from a commercial service if the patient with a non-government issue needs a replacement during a repair period. Use local funds for commercial rentals.

15.3.5. DHCs determine when a hearing aid has undergone an excessive number of repairs. The audiologist determines when replacement is needed.

15.4. Return of Unserviceable Hearing Aids: Patients return used hearing aids to the local medical logistics activity, which sends them to the nearest DHC.

15.5. Replacement Hearing Aids

15.5.1. DHCs replace lost or stolen hearing aids up to one time per year. Exceptions can be made by the issuing audiologist on a case-by-case basis.

15.5.2. A hearing aid has a minimum life span of 5 years. They will not be replaced more frequently except where there is an excessive repair record or the hearing aid is no longer appropriate for the hearing loss.

15.6. Accountability for Hearing Aids

15.6.1. The audiologist will:

15.6.1.1. Perform a quarterly inventory of all new hearing aids in stock.

15.6.1.2. Maintain the inventory in the clinic.

15.6.1.3. Maintain one copy of the letter authorizing issue of hearing aids to provide an audit trail for issued hearing aids, as well as for those obtained under the Retiree Hearing Aid Purchase Program.
Chapter 16

ALTERNATIVE MEDICINE SERVICES

Section 16A—Chiropractic Care

16.1. General Guidelines

16.1.1. Chiropractic evaluation and treatment are authorized for active duty in designated MTFs. Doctors of Chiropractic are offered appointment to the medical staff and are awarded privileges IAW 44-119.

16.1.2. Use of supplemental funding for chiropractic evaluation and treatment is not authorized.

16.2. Scope of Chiropractic Services. The scope of services shall be limited to evaluation and treatment of neuro-musculoskeletal conditions. The core of chiropractic care is the treatment and prevention of subluxation by chiropractic adjustment, and those procedures that are preparatory and complementary to such adjustments. Peripheral treatments may not be used as independent therapies or separated from chiropractic adjustment. Musculoskeletal complaints typically seen among military personnel on active duty that are appropriate to refer for chiropractic adjustment and care include:

16.2.1. Postural problems and asymmetries derived from non-structural (soft tissue) and structural (bony) origins.

16.2.2. Subluxations of the spine.

16.2.3. Peripheral complaints in which there is no fracture, joint dislocation or ligamentous disruption, and which are related to potential spinal pathology.

Section 16B—Acupuncture

16.3. Clinician Requirements: Physicians (MDs and DOs) privileged to perform acupuncture must meet the following requirements:

16.3.1. Must possess a current, valid, unrestricted state license to practice medicine.

16.3.2. Must possess a current, valid state license to practice medical acupuncture if required by the state where the provider is licensed.

16.3.3. Must complete a minimum of 200 hours of additional training in acupuncture through a CME program approved by the American Medical Association (AMA), the American Osteopathic Association (AOA), or the American Academy of Medical Acupuncture (AAMA). The only acceptable courses are those that meet World Health Organization (WHO) requirements and state licensing requirements for physician acupuncturists.

Section 16C—Internet Pharmacies

16.4. Active duty members are prohibited from obtaining medications, or using medications obtained from an Internet pharmacy not related to the TRICARE Pharmacy benefit. The Pharmacy benefit supplies medications through an MTF, a participating civilian pharmacy or thought the DOD TRICARE Mail Order Pharmacy (TMOP) Program.
Chapter 17

MEDICOLEGAL MATTERS

17.1. Medical Law Consultants (MLC)

17.1.1. The MLC advises commanders at medical facilities on all matters IAW AFI 51-302, Medical Law. The MLC’s commander ordinarily authorizes temporary duty (TDY) for the MLC to provide consultant visits to each base medical facility within MLC’s geographic area of responsibility at least once a year.

17.1.2. Refer to AFI 44-109, Mental Health and Military Law, for specific guidance on issues pertaining to communications between mental health providers and commanders.

17.2. Healthcare Provider and Patient Privileged Communications

17.2.1. A variety of official military proceedings and investigations may require medical personnel to act as a witness and otherwise to divulge confidential patient information. Military law enforcement personnel may seize government controlled health record information compiled during medical practice, of individuals subject to Uniformed Code of Military Justice (UCMJ) proceedings, regardless of the patient’s consent. The medical staff should make copies of the record to be seized for medical provider use pending resolution of the legal matter. **EXCEPTIONS:** a) Where the Staff Judge Advocate advises otherwise and b) When victims of sexual assault decide for restricted reporting IAW Department of Defense Directive DODD 6495.01. Contact the servicing Staff Judge Advocate for records pertaining to mental health care.

17.2.2. Any record may be opened upon the determination of a military or civil court.

17.2.3. Otherwise, medical records may only be released IAW provisions of Public Law 93-579, Privacy Act of 1974, HIPAA and DOD 6025-18R.

17.3. Biological Specimens in Administrative or Judicial Proceedings

17.3.1. Specimens as Evidence: Since the results of examinations of biological specimens as well as the specimens themselves may be used as evidence in military and civilian judicial or administrative proceedings, the AFMS must cooperate in collecting and presenting such evidence.

17.3.2. Principles Governing Handling of Biological Specimens

17.3.2.1. Medical personnel may take biological specimens IAW the Air Force drug testing program and IAW the AF Sexual Assault Prevention and Response Program.

17.3.2.2. The donor must consent to any medical personnel taking and using biological specimens as evidence.

17.3.2.3. Where the donor does not consent:

17.3.2.3.1. Attempt to consult SJA before drawing blood.

17.3.2.3.2. Medical personnel may take blood without the donor’s consent and without a search warrant or search authorization only when there is a clear indication that evidence of crime will be found and law enforcement authorities have reason to believe that the delay that
would result if a warrant or authorization were sought could result in the destruction of the evidence.

17.3.2.3. Medical personnel may take blood without the donor’s consent and without a search warrant or search authorization when there is a clear indication that evidence of crime will be found and authorities (Wing/CC, SJA) have reason to believe that the delay would result in the destruction of evidence.

17.3.2.4. Involuntary extraction of blood must be performed in a reasonable fashion by personnel with appropriate medical qualifications. Unless unsafe, medically trained personnel may restrain a donor, however, Security Forces personnel shall assist medically trained personnel when appropriate.

17.3.2.5. Medical personnel may take biological specimens requiring visual examination of the unclothed body (such as pubic hair samples and dried fluids from the pubic area) without consent of the patient if they meet the requirements noted above for blood extraction:

17.3.2.5.1. With a search warrant or search authorization.

17.3.2.5.2. Without a search warrant or search authorization only when there is a clear indication that evidence of crime will be found and law enforcement authorities have reason to believe that the delay that would result if a warrant or authorization were sought could result in the destruction of the evidence.

17.3.2.6. The nonconsensual taking of other biological specimens that do not require visual examination of the unclothed body, or intrusion into the body, such as fingernail scrapings and hair samples from the head, does not require a search warrant or search authorization. A competent authority may order such nonconsensual takings. The SJA shall be consulted in matters such as this.

17.3.2.7. Military medical personnel may not take biological specimens solely at the request of and for the use of civilian law enforcement authorities.

17.3.2.8. MTF/CC will ensure procedures are in place to ensure that witnesses can identify specimens.

17.3.2.9. MTF/CC will ensure specimens are kept either in the exclusive custody of an identifiable person or secured in an identifiable, tamper-proof location from the time personnel collect the specimen to the time it is offered as evidence. MTF/CC must be able to demonstrate that these precautions were taken.

17.4. Reporting Serious Incidents

17.4.1. Healthcare providers will report all Active Duty sexual assaults to the SARC for determination of restricted versus unrestricted reporting. The SARC will conduct AFOSI notification as appropriate. All other incidents i.e. child abuse, spousal abuse, homicides, suicides, attempted suicides, robbery, aggravated assault, intentional prescription drug overdose and narcotic overdose episodes will be reported to the appropriate authorities.
Chapter 18

FORMS PRESCRIBED

18.1. IMT Forms Prescribed: This instruction prescribes the following forms:
AF Form 579, Controlled Substances Register;
AF Form 582, Pharmacy Stock Record;
AF Form 614, Charge Out Record;
AF Form 781, Multiple Item Prescription;
AF Form 1302, Request and Consent for Sterilization;
AF Form 1412, Occupational Therapy Treatment Record;
AF Form 1535, Physical Therapy Consultation,
AF Form 1536, Physical Therapy Consultation Continuation Sheet,
AF Form 1721, Spectacle Prescription,
AF Form 1722, Optometrical Examination Record,
AF Form 2380, Pharmacy Manufacturing Control Data,
AF Form 2381, Pharmacy Master Formula,
AF Form 2382, Pharmacy Bulk Compounding Chronological Control Log,
AF Form 2383, Prescriber Information,
AF Form 2700, Radiographic Film Envelope,

18.2. Personal Identification

18.2.1. The following forms collect the patient’s name and social Security Number, but none of the forms listed are annotated by the patient.
AF Form 422, Physical Profile Serial Report
AF Form 614, Charge Out Record
AF Form 765, Medical Treatment Facility Incident Statement
AF Form 781, Multiple Item Prescription
AF Form 1225, Informed Consent for Blood Transfusion
AF Form 1302, Request and Consent for Sterilization
AF Form 1412, Occupational Therapy Treatment Record
AF Form 1535, Physical Therapy Consultation
AF Form 1536, Physical Therapy Consultation Continuation Sheet
AF Form 1721, Spectacle Prescription
AF Form 1722, Optometric Examination Record
AF Form 2383, Prescriber Information
AF Form 2700, Radiographic Film Envelope
AF Form 3066, Doctor’s Orders
AF Form 3069, Medication Administration Record
DD Form 741, Eye Consultation
DD Form 771, Eyewear Prescription
DD Form 1150, Request for Issue and Turn In Slip
DD Form 2081, New Drug Request
DD Form 2351, Medical Examination Review Board (DODMERB) Report of Medical Examination
DD Form 2766, Acute and Chronic History
DD Form 2766C, Vaccine Administration Record
SF 88, Report of Medical Examination
SF 513, Medical Records Consultation
SF 519B, Medical Record-Radiographic Consultation Request/Report
SF 522, Medical Record-Request for Administration of Anesthesia
SF 600, Health Record-Chronological Record of Medical Care
SF 603, Health Record-Dental
SF 858, Emergency Care and Treatment

18.3. IMT Forms Adopted

18.3.1. This instruction makes reference to the following forms prescribed in other AFIs:
AF Form 85A, Inventory Adjustment Voucher, AFM 67-1V1;
AF Form 422, Physical Profile Serial Report, AFI 48-123;
AF Form 765, Medical Treatment Facility Incident Statement, AFI 44-119;
AF Form 847, Recommendation for Change of Publication, AFI 11-215;
AF Form 1225, Informed Consent for Blood Transfusion, AFI 44-105;
AF Form 3066, Doctor’s Orders, AFI 41-210;
AF Form 3069, Medication Administration Record, AFI 41-210;
DD Form 741, Eye Consultation,
DD Form 771, Eyewear Prescription,
DD Form 1150, Request for Issue and Turn In Slip
DD Form 2081, *New Drug Request*,

DD Form 2351, *Medical Examination Review Board (DODMERB) Report of Medical Examination*, AFJI 36-2018,

DD Form 2766C, *Vaccine Administration Record*,

SF 88, *Report of Medical Examination*,

SF 509, *Medical Record-Progress Note*

SF 513, *Medical Records Consultation*,

SF 518, *Blood or Blood Component Transfusion Medical Record*

SF 519B, *Medical Record-Radiographic Consultation Request/Report*,

SF 522, *Medical Record-Request for Administration of Anesthesia*,

SF 600, *Health Record-Chronological Record of Medical Care*,

SF 603, *Health Record-Dental*,

SF 858, *Emergency Care and Treatment*,

GEORGE PEACH TAYLOR, JR., Lt General, USAF, MC, CFS
Surgeon General
Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Federal Food, Drug, and Cosmetics Act

Public Law 86-571, 42 U.S.C. 1313, and 45 CFR 211 and 212, The Repatriate Program of Assistance to Mentally Ill US Citizens/Nationals Returned from Foreign Countries

Public Law 91-601, Poison Prevention Packaging Act of 1970

Public Law 93-579, Privacy Act of 1974

Public Law 104-191, Health Insurance Portability and Accountability Act of 1996

Public Law 104-204, Newborns’ and Mothers’ Health Protection Act of 1996

Title 21, U.S.C. 352 and 353, Misbranded Drugs and Devices, and Exemptions

Title 42 U.S.C. 1395dd., Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA), 1985

Title 21, U.S.C. 829 and 1309, concerning Prescribing and Dispensing Controlled Substances

16 CFR, Sections 1700-1704, Poison Prevention Packaging Act

21 CFR 50.23(d), Protection of Human Subjects

21 CFR 900, Mammography Accreditation

21 CFR 1301.75, Physical Security Controls for Practitioners

45 CFR 211, 212, US Citizens Returned From Foreign Countries

OASD (HA) Policy 97-1019, Off-Duty Employment by DOD Dental Care Providers, December 10, 1996

DODD 1010.1, Military Personnel Drug Abuse Testing Program, January 11, 1999

DODD 6000.14, Patient’s Bill of Rights and Responsibilities in the Military Health System, March 17, 1999

DODD 6025.13, Clinical Quality Management Program in the Military Health System, July 20, 1995

DODD 6025.14, DOD Participation in the National Provider Data Bank, November 1, 1990

DOD 6025.18R, DOD Health Information Privacy Regulation, January 24, 2003

DODD 6040.37, Confidentiality of Medical Quality Assurance (QA) Records, July 9, 1996

DODD 6465.3, Organ and Tissue Donation, March 16, 1995

DODD 6495.01, Sexual Assault Prevention and Response (SAPR) Program, October 6, 2005

Department of Defense Instruction DODI 6025.8, Ambulatory Procedure Visit, September 23, 1996

Office of the Assistant Secretary of Defense (Health Affairs) OASD (HA) Policy 96-00050, Policy for Off-Duty Employment by DOD Health Care Providers, July 23, 1996

DODI 6440.2, Clinical Laboratory Improvement Program (CLIP), April 20, 1994
DOD Financial Management Regulation. Volume 11A, Chapter 6, Appendix H. Medical and Dental Services Rate Computation

AFPD 44-1, Medical Operations
AFI 10-248, Fitness Program
AFI 36-2110, Assignments
AFI 36-3003, Military Leave Program
AFI 38-101, Air Force Organization
AFI 40-101, Health Promotion Program
AFI 40-402, Protection of Human Subjects in Biomedical and Behavioral Research
AFI 41-114, Military Health Services System (MHSS) Matrix
AFI 41-115, Authorized Health Care and Health Care Benefits in the Military Health Services System
AFI 41-117, Medical Service Officer Education
AFI 41-209, Medical Logistics Support
AFI 41-210, TRICARE Operations and Patient Administration Functions
AFI 44-103, The Air Force Independent Duty Medical Technician Program and Medical Support for Mobile Medical Units/Remote Sites
AFI 44-105, The Air Force Blood Program,
AFI 44-109, Mental Health and Military Law
AFI 44-119, Clinical Performance Improvement
AFI 46-101, Nursing Services and Operations
AFI 46-102, Nursing Care
AFI 47-101, Managing Air Force Dental Services
AFI 48-101, Aerospace Medical Operations
AFI 48-105, Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance
AFI 48-110, Immunization and Chemoprophylaxis
AFI 48-123, Medical Examinations and Standards
AFI 48-135, Human Immunodeficiency Virus Program
AFI 48-145, Occupational Health Program
AFI 51-302, Medical Law
AFI 91-204, Safety Investigations and Reports
AFIP Pamphlet 40-24, Department of Defense Clinical Laboratory Improvement Program
AFMAN 32-4006, Nuclear, Biological, and Chemical (NBC) Mask Fit and Liquid Hazard Simulant Training
AFMAN 37-139, Records Disposition Schedule
AAP Statement, Breastfeeding and the Use of Human Milk, 1997
AAP Statement Hospital Stay for Healthy Term Newborns, 1995
ACOG and AAP, Browsing Guidelines for Perinatal Care, 2003
ACOG Guidelines for Women’s Health Care, 2001
Association of Operating Room Nurses (AORN) Standards, Recommended Practices and Guidelines, 2002
Comprehensive Accreditation Manual for Hospitals, current edition
United States Pharmacopoeia

Abbreviations and Acronyms
AAP—American Academy of Pediatrics
ACIP—Advisory Committee on Immunizations Practices
ACLS—Advanced Cardiac Life Support
ACOG—American College of Obstetricians and Gynecologists
AED—Automated External Defibrillator
AFB—Air Force Base
AFCITA—Air Force Complete Immunizations Tracking Application
AFI—Air Force Instruction
AFIP—Armed Forces Institute of Pathology
AFMAN—Air Force Manual
AFMOA/SGOC—Air Force Medical Operations Agency/Clinical Quality Management Division
AFMS—Air Force Medical Service
AFOSI—Air Force Office of Special Investigations
AFPD—Air Force Policy Directive
AFRC—Air Force Reserve Component
AFSC—Air Force Specialty Code
AF/SG—Air Force Surgeon General
AHA—American Heart Association
A/I—Allergy/Immunizations
AIDS—Acquired Immunodeficiency Syndrome
AIT—Allergy Immunotherapy
AMA—American Medical Association
ANG—Air National Guard
AORN—Association of Operating Room Nurses
APhA—American Pharmaceutical Association
ARC—American Red Cross
ASA—American Society of Anesthesiology
ASBPO—Armed Services Blood Program Office
ASHP—American Society of Health-System Pharmacists
BCF—Basic Core Formulary
BDC—Blood Donor Center
BEE—Bio-Environmental Engineering
BLS—Basic Life Support
CCU—Coronary Care Unit
CDC—Career Development Course
CFM—Career Field Manager
CFR—Code of Federal Regulations
CHCS—Composite Healthcare System
CONUS—Continental United States
CPR—Cardiopulmonary Resuscitation
CRNA—Certified Registered Nurse Anesthetist
CSP—Compounded Sterile Product
CWDE—Chemical Warfare Defense Ensemble
DEA—Drug Enforcement Administration
DHC—Diagnostic Hearing Center
DHHS—Department of Health and Human Services
DOD—Department of Defense
DODD—Department of Defense Directive
DODI—Department of Defense Instruction
DODMERB—Department of Defense Medical Examination Review Board
EMTALA—Examination and Treatment for Emergency Medical Conditions and Women in Labor
FDA—Food and Drug Administration
GMP—Good Manufacturing Practices
GSA—United States General Services Administration
HIPPA—Health Insurance Portability and Accountability Act
HIV—Human Immunodeficiency Virus
HQ ARPC/SGS—Headquarters, Air Reserve Personnel Center/SGS
HSI—Health Services Inspections
IA—Immunization Augmentee
IAW—In Accordance With
IBT—Immunization Back-up Technician
ICU—Intensive Care Unit
IDMT—Independent Duty Medical Technician
IMA—Individual Mobilization Augmentee
INTACS—Intrastromal Ring Segments
JCAHO—Joint Commission on Accreditation of Healthcare Organizations
LASIK—Laser In Situ Keratomileusis
LPN—Licensed Practical Nurse
MAJCOM/SG—Major Command Surgeon
MLC—Medical Law Consultant
MNT—Medical Nutrition Therapy
MOA—Memorandum of Agreement
MOU—Memorandum of Understanding
MPF—Military Personnel Flight
MTC—Military Transplant Center
MTF—Military Treatment Facility
NCO—Non-Commissioned Officer
NRP—Neonatal Resuscitation Program
OASD(HA)—Office of the Assistant Secretary of Defense (Health Affairs)
OB—Obstetrics
OB/GYN—Obstetrics and Gynecology
OIC—Officer in Charge
OMG—Objective Medical Group
OSHA—Occupational Safety and Health Administration
PA—Physician Assistant
PACU—Post-Anesthesia Care Unit
PALS—Pediatric Advanced Life Support
PCS—Permanent Change of Station
PRK—Photorefractive Keratectomy
QA—Quality Assurance
RDS—Air Force Records Disposition Schedule
RK—Radial Keratotomy
SCU—Special Care Unit
SGH—Chief, Professional Staff
SGP—Chief, Aeromedical Services
TDY—Temporary Duty
UCMJ—Uniformed Code of Military Justice
USAF—United States Air Force
US—United States
USU—Uniformed Services University of the Health Service
VA—Veterans Administration
WHO—World Health Organization

Terms

Biological Specimen—a sample from the body
Case Management—the monitoring, planning and coordination of treatment of patients with complex conditions
Contrast Media—substances that permit radiographic demonstration of a space, a potential space or an organ
Controlled Substances—drugs so designated by the Attorney General because of demonstrated or potential abuse. Five schedules are used to classify controlled substances by potential for abuse.
Cosmetic Surgery—surgery performed only to improve physical appearance
Credentials—the documents that constitute evidence of training, licensure, experience and expertise of a provider
Healthcare Providers—Military (Active or Reserve component) and civilian personnel (Civil Service and other providers working under contractual or similar arrangement) granted privileges to diagnose medical conditions and initiate, alter or terminate healthcare treatment regimes within the scope of his or her license, certification or registration. This category includes physicians, dentists, nurse providers, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical dieticians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician
assistants or any other professional providing direct patient care.

**Inborn Diseases**—pertaining to a constitutional characteristic that is inherited or implanted during intrauterine life

**Purchased Care System**—medical care provided outside the Air Force Medical Service

**Moderate Sedation**—a minimally depressed level of consciousness that allows the patient to retain the ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic method, non-pharmacologic method or a combination of the two. Sedating procedures, which would result in the loss of protective reflexes for a significant percentage of a group of patients, are not considered conscious sedation.

**Occupational illness**—Any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to factors associated with employment. It includes acute and chronic illnesses or diseases that may be caused by inhalation, absorption, ingestion, or direct contact. See the Department of Labor, Bureau of Labor Statistics, Occupational Injury and Illness Classification Manual for further details.

**Occupational injury**—Any injury such as a cut, fracture, sprain, amputation, etc., which results from a work-related event or from a single instantaneous exposure in the work environment.

**Privileges (clinical)**—permission to provide medical and other patient care services in the granting institution within defined limits based on the individual’s education, professional licensure, experience, competence, ability, health and judgment. Request is evaluated by the credentials function and approved by the MTF Commander.

**Primary Care Manager**—healthcare provider who oversees and coordinates the general preventive, diagnostic and therapeutic care for a particular patient

**Special Care Unit**—any type of critical care unit with a dedicated nursing staff and administrative support

**Supervision**—process of reviewing, observing and accepting responsibility for assigned personnel. Indirect supervision is where the supervisor does a retrospective record review of selected records. Direct supervision requires the supervisor to be involved in decision-making processes either by verbal contact or by being physically present through all or part of the care.

**Qualified Assistant**—a physician designated by the Credentials Function of the Military Treatment Facility as being qualified to assist with a particular type of procedure.