Medical In/Out-Processing Worksheet (v21)

Prior to submitting this form, make a copy of this Worksheet and Disclosure Form (if applicable) to give to your gaining base at Medical Right Start. Clinic staff will shred the worksheet once transcribed into the EHR. Clinic staff WILL NOT SCAN INTO AHLTA.

Date	☐ IN Processing			☐ OUT Processing			
Branch of Service	☐ USA	☐ USN	☐ USAF	☐ USMC	☐ USCG		
Check All that Apply	☐ AD	☐ Reserve	☐ Retired	☐ PCS	☐ TDY	☐ Joint Base Move	☐ Separating/Retiring	☐ Dependent

Losing Base	Final Out Date from Losing Base	Gaining Base	Arrival Date at Gaining Base

Name (Rank, Last, First MI)	Complete DoD ID Number or Last 4 SSN	DOB (dd-mmm-yyyy)

Phone Number (cell)	Phone Number (office/DSN)	Phone Number (home)

Are you and your dependents enrolled in MiCare Secure Messaging? If **NO**, please list names and emails of all dependents 18 years or older who are not enrolled. ☐ YES ☐ NO

Name & Email	Name & Email	Name & Email

Are you transferring to or coming from overseas, including Hawaii or Alaska? ☐ YES ☐ NO

1) Will your dependents be accompanying you at your gaining base? I**f Yes, when**?

☐ YES ☐ Immediately ☐ 1-3 mos later ☐ 4-6 mos later ☐ NA - No Dependents

☐ NO - My dependents will physically reside at the following location:

2) Do you or your dependents have Asthma, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), or any other chronic medical condition that is treated by a Specialist (Cardiology, Neurology, Psychiatry, etc.)? **If Yes, please list name of family member and condition.** ☐ YES ☐ NO

3) Are you or your dependents enrolled with a case manager? **If Yes, please list family member below and the Case Manager's Name** _____ **Contact Number**_____**.** ☐ YES ☐ NO

4) Have you completed or are you in the process of completing a Family Member Relocation Clearance (FMRC) for your dependents enrolled in Exceptional Family Member Program (EFMP) or Educational and Developmental Interventional Services (EDIS)? ☐ YES ☐ NO ☐ NA

5) Are your dependents enrolled in the Exceptional Family Member Program (EFMP), Educational and Developmental Interventional Services (EDIS), or have any dependents been provided an Individual Family Service Plan (IFSP), or the Individualized Education Plan (IEP)? **If Yes, please list each person enrolled and which program.** ☐ YES ☐ NO ☐ NA

6) Have you or your dependents been seen by a medical or behavioral health provider for mental health concerns in the last 5 years? **If Yes, please list the name of family member.** ☐ YES ☐ NO

7a) Have you or your dependents been told you had an abnormal pap or enrolled in a cervical dysplasia program? **If Yes, please list the name of family member.** ☐ YES ☐ NO

7b) Do you or your dependent have any outstanding or pending referrals, labs, radiology, or medical test results? ☐ YES ☐ NO

If Yes, please list name of family member and outstanding/pending test or result.

Type AUTHORITY: 10 U.S.C. 55. 10 U.S.C 8013 and E.O. 9397 (SSN) as amended. PURPOSE(S): Used to document, plan, and coordinate the health care of Active Duty and family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data. ROUTINE USE: Used to accumulate information for determining Active Duty and family member's medical in/out processing needs. DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of Active Duty and family member's care when transitioning to new locations.

8) Would you like to speak with someone about a sensitive issue? **If Yes, please indicate which agency**. ☐ Medical Professional ☐ Mental Health Clinic ☐ Chaplain ☐ Family Advocacy ☐ Other _____	☐ YES ☐ NO ☐ NA
9) Have you deployed in the last 6 to 24 months? **If Yes, where and what time period were you deployed?**	☐ YES ☐ NO
10) Do you or your dependents need to have your medications refilled until you reach your next duty station? **If Yes, please list family member and medication needed.**	☐ YES ☐ NO
11) Have you had a Medical Evaluation Board (MEB)/ RILO completed in the past or is one in the process now? **If Yes, what is the expiration date of the MEB?**	☐ YES ☐ NO
12) Do you have a diagnosis of Post-traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI)?	☐ YES ☐ NO
13) Have you been, or are you currently enrolled in the Air Force Wounded, Ill, and Injured (AFWII) program?	☐ YES ☐ NO
14) Are you on Profile or have an Assignment Limitation Code? **If Yes**, **please explain:**	☐ YES ☐ NO
15) **For Active Duty Only -** Are you on Student Status?	☐ YES ☐ NO
16) **For Active Duty Only** - If stationed overseas, did you receive a Blood Transfusion? (AFI 44-102) ☐ NA	☐ YES ☐ NO
17) Are you or your dependents pregnant? **If Yes, please schedule a Follow Up OB appointment upon arriving at your gaining base.** ☐ Unsure ☐ NA	☐ YES ☐ NO
18) If you answered **Yes to #17**, is the pregnancy high risk? ☐ Unsure ☐ NA	☐ YES ☐ NO
19) Do you have any children under 23 months old? ☐ NA	☐ YES ☐ NO
20) Do you know if their Well Baby Visits and Immunizations are up-to-date? ☐ Unsure ☐ NA	☐ YES ☐ NO

21) Are you on any of the following: (Check all that apply)

☐ PRP ☐ PSP ☐ Flying Status or 1042 Holder ☐ Other: ☐ NA

If you checked PRP, PSP, Flying Status or 1042 Holder, Go to Flight Medicine Clinic to complete Medical I/O Processing

22) Are you **Retiring?** ☐ YES ☐ NO If **Yes,** will you remain in the local area and continue to receive Care at the MTF? ☐ YES ☐ NO

If OUT-PROCESSING or RETIRING: It is your responsibility to obtain copies of medical records, results and/or refills of medications from off base Primary Care providers or Specialists. If you or your dependent had a Mammogram or Radiology Study, please obtain copy of films from the Radiology Department.

23) List the name and Date Of Birth (DOB) of each dependent that are physically here with Sponsor:

Name	DOB dd-mmm-yyyy	Name	DOB dd-mmm-yyyy.

Because email is not a HIPAA compliant method of sending personal health information, it is **NOT** recommended to send this form via email or MiCare Secure Messaging to the clinic. The recommended method of submitting this form is to hand carry to the clinic.

Below items are for clinical personnel only:

Sponsor's PCM or PCMH Team: _____ Is ASIMS/IMR Up-to-Date? ☐ Yes ☐ No

Patient ACG Score _____ **Other** _____ ACG Score _____ **Other** _____ ACG Score _____ **Child FMP** ____ ACG Score ____ **Child FMP** ____ ACG Score _____

Spouse ACG Score _____ **Child FMP** ____ ACG Score _____ **Child FMP** ____ ACG Score _____ **Child FMP** ____ ACG Score ____ **Child FMP** ____ ACG Score _____

X _____ X _____

Personnel Reviewing Form | Transcribed Above Info Into E-Medical Record

Clinical Representatives: Once transcribed into the electronic health record, this form must be returned to the HCI or designee for review. If Question 21 is checked for PRP, PSP, Flying Status or 1042 Holder, send form to Flight Medicine for review. **DO NOT SCAN INTO AHLTA!**

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