

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 <input style="width:100%;" type="text"/>	<input type="checkbox"/> IN Processing	<input type="checkbox"/> OUT Processing
Branch of Service	<input type="checkbox"/> USA	<input type="checkbox"/> USN
	<input type="checkbox"/> USAF	<input type="checkbox"/> USMC
	<input type="checkbox"/> USCG	
Check All that Apply <input type="checkbox"/> AD <input type="checkbox"/> Reserve <input type="checkbox"/> Retired <input type="checkbox"/> PCS <input type="checkbox"/> TDY <input type="checkbox"/> Joint Base Move <input type="checkbox"/> Separating/Retiring <input type="checkbox"/> Dependent		
Losing Base	Final Out Date from Losing Base	Gaining Base
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
Arrival Date at Gaining Base		
<input style="width:100%;" type="text"/>		
Name (Rank, Last, First MI)	Complete DoD ID Number or Last 4 SSN	DOB (dd-mmm-yyyy)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
Phone Number (cell)	Phone Number (office/DSN)	Phone Number (home)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
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.		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
Name & E-mail	Name & E-mail	Name & E-mail
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
Are you transferring to or coming from overseas, including Hawaii or Alaska?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
1) Will your dependents be accompanying you at your gaining base? If Yes, when?		
<input type="checkbox"/> Yes <input type="checkbox"/> Immediately <input type="checkbox"/> 1-3 mos later <input type="checkbox"/> 4-6 mos later <input type="checkbox"/> NA - No Dependents		
<input type="checkbox"/> NO - My dependents will physically reside at the following location: <input style="width:100%;" type="text"/>		
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.		<input type="checkbox"/> YES <input type="checkbox"/> NO
3) Are you or your dependents enrolled with a case manager? If Yes, please list the family member below and the Case Manager's Name _____ Contact Number _____.		<input type="checkbox"/> YES <input type="checkbox"/> 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)?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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.		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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.		<input type="checkbox"/> YES <input type="checkbox"/> NO
7a) Have you or your dependents been told you had an abnormal pap or enrolled in a cervical dysplasia program?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please list the name of family member. <input style="width:100%;" type="text"/>		
7b) Do you or your dependents have any outstanding or pending referrals, labs, radiology, or medical test results?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please list the names and outstanding / pending tests or results.		
<input style="width:100%; height: 20px;" type="text"/>		

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. <input type="checkbox"/> Medical Professional <input type="checkbox"/> Mental Health Clinic <input type="checkbox"/> Chaplain <input type="checkbox"/> Family Advocacy <input type="checkbox"/> Other: <input style="width:80px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> NA
9) Have you deployed in the last 6 to 24 months? If Yes, where and what time period were you deployed?	<input type="checkbox"/> YES <input type="checkbox"/> 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.	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
12) Do you have a diagnosis of Post-traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
13) Have you been, or are you currently enrolled in the Air Force Wounded, Ill, and Injured (AFWII) program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
14) Are you on Profile or have an Assignment Limitation Code? If Yes, please explain:	<input type="checkbox"/> YES <input type="checkbox"/> NO
15) For Active Duty Only - Are you on Student Status?	<input type="checkbox"/> YES <input type="checkbox"/> NO
16) For Active Duty Only - If stationed overseas, did you receive a Blood Transfusion? (AFI 44-102) <input type="checkbox"/> NA	<input type="checkbox"/> YES <input type="checkbox"/> NO
17) Are you or your dependents pregnant? If Yes, schedule a Follow Up OB appointment upon arrival at your gaining base. <div style="float: right; text-align: right;"> <input type="checkbox"/> Unsure <input type="checkbox"/> NA </div>	<input type="checkbox"/> YES <input type="checkbox"/> NO
18) If you answered Yes to #17 , is the pregnancy high risk? <div style="float: right; text-align: right;"> <input type="checkbox"/> Unsure <input type="checkbox"/> NA </div>	<input type="checkbox"/> YES <input type="checkbox"/> NO
19) Do you have any children under 23 months old? <div style="float: right; text-align: right;"> <input type="checkbox"/> NA </div>	<input type="checkbox"/> YES <input type="checkbox"/> NO
20) Do you know if their Well Baby Visits and Immunizations are up-to-date? <div style="float: right; text-align: right;"> <input type="checkbox"/> Unsure <input type="checkbox"/> NA </div>	<input type="checkbox"/> YES <input type="checkbox"/> NO
21) Are you on any of the following: (Check all that apply) <input type="checkbox"/> PRP <input type="checkbox"/> PSP <input type="checkbox"/> Flying Status or 1042 Holder <input type="checkbox"/> Other: <input style="width:80px;" type="text"/> <input type="checkbox"/> 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 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-yy	Name	DOB dd-mmm-yy
<input style="width:90%;" type="text"/>	<input style="width:80%;" type="text"/>	<input style="width:90%;" type="text"/>	<input style="width:80%;" type="text"/>
<input style="width:90%;" type="text"/>	<input style="width:80%;" type="text"/>	<input style="width:90%;" type="text"/>	<input style="width:80%;" type="text"/>
<input style="width:90%;" type="text"/>	<input style="width:80%;" type="text"/>	<input style="width:90%;" type="text"/>	<input style="width:80%;" type="text"/>

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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