TOTAL FORCE HEALTH READINESS FLOWSHEET

(This form is subject to the Privacy Act of 1974 - Use DD Form 2005)

PRIVACY ACT STATEMENT

AUTHORITIES: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Manual (DoDM) 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs; and E.O. 9397 (SSN).

PURPOSE: To collect patient information necessary to determine the patient's readiness to participate in a military deployment.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: Collected information may be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, healthcare operations, and the containment of certain communicable diseases. For a full listing of the applicable Routine Uses for this system, refer to the applicable SORN.

APPLICABLE SORN: EDHA 07, "Military Health Information System," (June 15, 2020, 85 FR 36190) **https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf**

DISCLOSURE: Voluntary. However, failure to provide the information requested may result in delays in assessing your dental health needs for military service and/or for possible deployment.

1. ALLERGIES

a. MEDICATION ALLERGIES	b. OTHER ALLERGIES

2. HEALTH CONDITIONS

a. DEPLOYMENT LIMITING HEALTH CONDITIONS	b. OTHER HEALTH CONDITIONS/MEDICAL EQUIPMENT REQUIREMENTS

3. MEDICATIONS	4. SUPPLEMENTS	5. HOSPITALIZATIONS	6. SURGERIES

7. COUNSELING

SAFE SEX/FAMILY PLANNING	**DATE**					
CONTRACEPTIVE COUSELING *(Pre-Deployment)*	**DATE**					
TRAVEL	**DATE**					
SICKLE CELL TRAIT (SCT)	**DATE**					
OTHER	**DATE**					

LIVING WILL/DATE FILED:

8. OCCUPATIONAL HISTORY/RISK

a. PRP	☐ YES	☐ NO	
b. AUOF	☐ YES	☐ NO	
c. FLYING STATUS	☐ YES	☐ NO	
d. DIVE/SUBMARINER	☐ YES	☐ NO	
e. OTHER:	☐ YES	☐ NO	*If other, specify:*

INDIVIDUAL'S IDENTIFICATION *(Use this space for mechanical imprint)*

RECORDS MAINTAINED AT:

INDIVIDUAL'S NAME			SEX
LAST	FIRST	M.I.	☐ MALE ☐ FEMALE

STATUS	RANK/GRADE	DEPT/SERVICE

ORGANIZATION	DoD EIN/SSN	DATE OF BIRTH

TOTAL FORCE HEALTH READINESS FLOWSHEET

9. FAMILY HISTORY *(Service Members Only) (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather)*

a. CANCER *(Specify)*	
b. CARDIOVASCULAR DISEASE *(Specify)*	
c. DIABETES *(Specify)*	
d. MENTAL ILLNESS/CHEMICAL DEPENDENCY *(Specify)*	
e. OTHER *(Specify)*	

10. SCREENING EXAMS *(N = Normal, AB = Abnormal, NA = Not Indicated per USPSTF or Service Policy)*

a. TEST	b. LAST/DATE	c. N/AB	d. RESULT	b. DATE	c. N/AB	d. RESULT	b. DATE	c. N/AB	d. RESULT
(1) WEIGHT									
(2) HEIGHT									
(3) BLOOD PRESSURE									
(4) CHOLESTEROL									
(5) ASCVD RISK SCORE									
(6) HEARING									
(7) ORAL/DENTAL									
(8) EYE/VISION									
(9) PAP SMEAR									
(10)									
(11)									

11. IMMUNIZATIONS (*Enter date for each dose as ddmmyyyy. Where applicable enter titer date and Medical Immune exemption as "MI –ddmmyyyy". Enter type of immunization above date in split boxes for lines e, g, l, o.)*

a. Hep A / Titer						
b. Hep B / Titer						
c. Twinrix						
d. MMR / Titer						
e. Varicella / Titer						
f. Td or Tdap						
g. Polio						
h. Influenza *(NH or SH)*						
i. COVID-19						
j. Yellow Fever						
k. Meningococcal ACWY						
l. Japanese Encephalitis						
m. Typhoid *(Vivotif or Typhim VI)*						
n. Rabies						
o. Anthrax						
p. Smallpox *(ACAM or Jynneos)*						
q. Other:						
r. Other:						
s. PPD or IGRA *(Enter mm or result and date)*	(1a) mm/result	(2a) mm/result	(3a) mm/result	(4a) mm/result	(5a) mm/result	(6a) mm/result
	(1b) DATE	(2b) DATE	(3b) DATE	(4b) DATE	(5b) DATE	(6b) DATE

DoD EIN/SSN	NAME

TOTAL FORCE HEALTH READINESS FLOWSHEET

12. READINESS

a. DNA/DATE	b. BLOOD TYPE/DATE/RESULT	c. RH / DATE / RESULT:	d. SICKLE CELL SCREEN/ DATE/RESULT:

e. G6PD *(Glucose-6-phosphate dehydrogenase)*	DATE	QUALITY	QUANTITY

f. PHA *(DD3024)*	DATE (1)	DATE (2)	DATE (3)	DATE (4)	DATE (5)	DATE (6)

g. DENTAL EXAM	(1) DATE / CLASS	(2) DATE / CLASS	(3) DATE / CLASS	(4) DATE / CLASS

h. PERMANENT PROFILE CHANGE/WAIVER?	(1) DATE/LENGTH OF WAIVER	(2) P:	(3) U:	(4) L:	(5) H:	(6) E:	(7) S:

DEPLOYMENT WAIVERS:	(1) DATE	TYPE	(2) DATE	TYPE

i. GLASSES/GASMASK Rx: _____	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

j. HEARING AIDS/ BATTERIES	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

HEARING AID TYPE:	BATTERY TYPE REQUIRED FOR HEARING AID:

k. HEARING PROTECTION DEVICE (HPD)	SINGLE HPD TYPE:	DUAL HPD TYPE:	ENHANCED COMMUNICATION PROTECTION:

l. HIV Test	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

13. DEPLOYMENT HEALTH (DH)

a. LOCATION CCMD						
b. LOCATION COUNTRY						
c. DH REQUIREMENTS COMPLETED	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
(1) RECORD REVIEW						
(2) PRE-DHA *(DD2795)*						
(3) WALKING BLOOD BANK	SCREENED: ☐ Y ☐ N ELIGIBLE: ☐ Y ☐ N	SCREENED: ☐ Y ☐ N ELIGIBLE: ☐ Y ☐ N	SCREENED: ☐ Y ☐ N ELIGIBLE: ☐ Y ☐ N	SCREENED: ☐ Y ☐ N ELIGIBLE: ☐ Y ☐ N	SCREENED: ☐ Y ☐ N ELIGIBLE: ☐ Y ☐ N	SCREENED: ☐ Y ☐ N ELIGIBLE: ☐ Y ☐ N
(4) ANAM						
(5) PRE-DEPLOYMENT SERUM						
(6) MHA IN THEATER *(DD2978)*						
(7) PDHA *(DD2796)*						
(8) MHA REDEPLOYMENT *(DD2978)*						
(9) POST-DEPLOYMENT SERUM						
(10) SHPE/SHA *(if required)*						
(11) PDHRA *(DD2900)*						
(12) DMHA4 *(DD2978/3024)*						
(13) DMHA5 *(DD2978/3024)*						

d. FORCE HEALTH PROTECTION RX	ITEM	DOSE	QUANTITY ISSUED	ISSUE DATE

DoD EIN/SSN	NAME

TOTAL FORCE READINESS FLOWSHEET

(Continuation Sheet)

OTHER *(Test, Exam, etc.)*	**FREQ**	**DATE**	**RESULTS/NOTES**

REMARKS

INDIVIDUAL'S IDENTIFICATION *(Use this space for mechanical imprint)*	RECORDS MAINTAINED AT:		
	INDIVIDUAL'S NAME LAST / FIRST / M.I.		SEX ☐ MALE ☐ FEMALE
	STATUS	RANK/GRADE	DEPT/SERVICE
	ORGANIZATION	DoD EIN/SSN	DATE OF BIRTH