

MEDBASE SRP PROCESS
Ft. Bliss, Texas

SRP Data Information Worksheet

Personal / Demographic data

First Name		Street Address:	
Middle Initial		City:	
Last Name:		State:	
SSN:		ZIP:	
DOB:		Home Phone	
Gender <i>Circle one</i>	Male Female	Work Phone (Optional)	
Marital Status <i>Circle one</i>	M S D W	Email (Optional)	
Race		UIC (unit code) <i>see orders</i>	
Blood Type <i>Circle one</i>	A- A+ B- B+ UNK AB+ O- O+ AB-	Pay Grade (E-1, GS-1, WS-1, etc):	

Current Primary Status

Service	<i>Circle one</i>	Component	<i>Circle one</i>	Military Status	<i>Circle one</i>
	Army		Active Duty		Active Duty Enlisted
	Air Force		National Guard		Active Duty Officer
	Marines		Reserves		Cadet
	Navy		DOD Civilian		NG Enlisted
	Civilian		Contractor		NG Officer
	Coast Guard		Other		Resv. Enlisted
	Other		Unknown		Resv. Officer

Notes:

Information Entered into MEDBASE by: _____
(Last name, First name)

DEPLOYMENT VISION READINESS DATA FORM

Deploying to: _____ Processing Location _____

1. Today's Date: _____
2. Name: _____ 3. SSN: _____ - _____ - _____
4. Grade: _____ 5. Duty MOS _____
6. Branch: Army _____ Navy _____ Air Force _____ Marines _____ Other _____
7. Component: Active Duty _____ Reserve _____ National Guard _____ Other _____
8. Unit/Organizatoion _____
9. Number of military glasses you have? Not Required _____ 0 _____ 1 _____ 2 _____
If answer is 0 then check reason below why:
 never ordered never received no previous exam/screening
 lost/stolen broked/damaged not usable(wrong Rx,fit,type ect.)
10. Do you have mask inserts? Not Required _____ Yes _____ No _____
If no check reason below why: *W/HY*
 never ordered never received no previous exam/screening
 lost/stolen broken/damaged not usable(wrong Rx,fit,type, ect.)
11. Entrance Habitual Visual Acuity:
OD 20/ _____ OS 20/ _____ Pass _____ Fail _____ Minimum passing VA 20/30
If failed, then check reason below:
 no previous eam/screening no optical devices inadequate optical devices
other _____
12. Do you wear contact lenses? _____ Yes _____ No
13. Do you have any significant ocular health problems? _____ Yes _____ No
If yes what is the primary diagnosis? _____

AS A REASULT OF THIS VISIT:

How many clear spectacle were ordered 0 _____ 1 _____ 2 or more _____
How many sunglass spectacles were ordered 0 _____ 1 _____ 2 or more _____
How many mask inserts were ordered 0 _____ 1 _____ 2 or more _____

CONSENT TO RECEIVE ANTHRAX VACCINE

I have read or have had explained to me the information about anthrax and anthrax vaccine on pages 1 through 5 of this document. I understand:

- The benefits and risks of anthrax vaccination.
- The conditions (including pregnancy or possible pregnancy) that would exclude me from receiving anthrax vaccination.
- The expected side effects from anthrax vaccination.
- The full shot series of 6 shots over 18 months (3 in the first 4 weeks).
- Anthrax vaccination is voluntary for me.

I consent to receiving anthrax vaccination.

Signature of person receiving vaccination: _____

Date: _____

Information about the person receiving the vaccination. (Please print.)

Last Name _____ First _____ Middle _____

Birth date _____ (mm/dd/yyyy).

Social Security Number _____

Street _____ City _____ State _____

Zip or Postal Code _____ Country _____

=====
Clinic/Health Unit Information. (Please Print.)

Clinic Name _____

Street _____ City _____ State _____

Postal Code _____ Country _____ Vaccination Date _____

=====
PRIVACY ACT STATEMENT:

AUTHORITY: Sections 113, 3013, 5013, and 8015 of Title 10, United States Code and Executive Order 9397.

PRINCIPAL PURPOSE: To document your understanding of important information about anthrax and anthrax vaccine and that you voluntarily consent to receiving it.

ROUTINE USES: None.

DISCLOSURE: Voluntary, but failure to do so may prevent the Department of Defense from giving you the anthrax vaccination.

CONSENT TO RECEIVE SMALLPOX VACCINE

I have read or have had explained to me the information about smallpox and smallpox vaccine on pages 1 through 6 of this document. I understand:

- The benefits and risks of smallpox vaccination.
- The conditions (including pregnancy or possible pregnancy) that would exclude me from receiving smallpox vaccination.
- What to expect at the smallpox vaccination site.
- How the vaccination site should be cared for.
- The expected side effects from smallpox vaccination.
- Smallpox vaccination is voluntary for me.

I consent to receiving smallpox vaccination.

Signature of person receiving vaccination: _____

Date: _____

Information about the person receiving the vaccination. (Please print.)

Last Name _____ First _____ Middle _____

Birth date _____ (mm/dd/yyyy).

Social Security Number _____

Street _____ City _____ State _____

Zip or Postal Code _____ Country _____

=====

Clinic/Health Unit Information. (Please Print.)

Clinic Name _____

Street _____ City _____ State _____

Postal Code _____ Country _____ Vaccination Date _____

=====

PRIVACY ACT STATEMENT:

AUTHORITY: Sections 113, 3013, 5013, and 8015 of Title 10, United States Code and Executive Order 9397.

PRINCIPAL PURPOSE: To document your understanding of important information about smallpox and smallpox vaccine and that you voluntarily consent to receiving it.

ROUTINE USES: None.

DISCLOSURE: Voluntary, but failure to do so may prevent the Department of Defense from giving you the smallpox vaccination.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Smallpox Vaccination Initial Note Page 2 (2-Page Format)

45657

This page to be completed by a health care provider

1. Provider Assessment Date (MM/DD/YYYY)

If Provider Assessment Date or Action Taken Immunization Date is blank, Default is "Today's date" on page 1.

□□ / □□ / □□□□

2. Reason for Vaccination (Indicate One):

- Pre-outbreak: disease prevention
- Post-outbreak: not exposed to virus
- Post-outbreak: exposed to virus
- Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and interview (Check all that apply):

- | | | | |
|-------------------|-----------------------|-----------------------------|----------------------------------|
| | Self | | Close Contact |
| No restriction | <input type="radio"/> | | <input type="radio"/> |
| Pregnancy | <input type="radio"/> | | <input type="radio"/> |
| Immune supression | <input type="radio"/> | | <input type="radio"/> |
| Skin condition | <input type="radio"/> | | <input type="radio"/> |
| Relevant allergy | <input type="radio"/> | | |
| Heart condition | <input type="radio"/> | 3+ RF <input type="radio"/> | <input type="radio"/> (Describe) |
| Unsure | <input type="radio"/> | | |

4. Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevent diagnosis

5. Provider Decision and Plan (Check all that apply):

- Vaccinate: Primary (e.g. birth year > 1972, military entry > 1984)
- Vaccinate: Revaccination
- Medically immune: vaccinated within approp interval (MI)
- Vaccination deferred: Pending consult or lab test
- Vaccination deferred: Temporary contraindication (MT)
- Vaccination contraindicated unless exposed (MP)
- Vaccination not given (other reason specify below):

6. IF NOT IMMUNIZED, Check all that apply:

- Reason for non-immunization explained
- Lab test requested
- Consult request written/sent
- Follow up appointment planned
- Other reason (specify below):

List labs or consults requested, and length of temp referrals

Provider Signature and Printed Name/Stamp:

Last Name

□□□□□□□□□□□□□□□□□□

First Name

□□□□□□□□□□□□□□□□□□ MI

Social Security Number

□□□ - □□ - □□□□□□

VACCINE ADMINISTRATION:

Vaccination Date (M M / D D / Y Y Y Y)

7. Vaccination Action Taken: □□ / □□ / □□□□

Location: Left Arm Right Arm Other location (describe)

Number of Jabs: □□ □□

Lot # □□□□□□□□□□ Mfr □□□□

For QA use: local vial serial # □□□□

8. IF IMMUNIZED, Check all that apply:

- Information sheet given to recipient
- Recipient advised about post-vaccination reaction and care
- Reasons for follow-up clinic visit described
- Patient understands information given
- Bandages provided if needed

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Vaccine administered by: (Signature and Printed Name/Stamp)

Patient's Identification (May use for mechanical imprint)

- RECORDS MAINTAINED AT:
 RANK/GRADE
 SEX
 DATE OF BIRTH
 SPONSOR NAME
 (or Sponsor SSN)
 RELATIONSHIP TO SPONSOR
 (or FMP)
 ORGANIZATION
 STATUS
 DEPT/SVC