# REDEPLOYMENT/DEMOBILIZATION MEDICAL AND DENTAL SCREENING FOR INDIVIDUAL AUGMENTEE (IA) RETURNING FROM OVERSEAS CONTINGENCY OPERATIONS SUPPORT ASSIGNMENTS (OSA)

(This form must be completed in conjunction with DD Form 2697, Report of Medical Assessment and DD Form 2796, Post-Deployment Health Assessment)

| Service Member Name *(Last, First, MI)* | Rate / Rank | SSN |
|---|---|---|
| Deployment AOR | Active Component/Reserve Component | |

## PART I - MEDICAL/DENTAL SCREENING

(Responses in shaded areas must be explained in NMPS comments)

| | | | |
|---|---|---|---|
| **A. REVIEW** | | | |
| 1. Service Member has medical record in hand. | ☐ YES | ☐ NO | |
| 2. Service Member has dental record in hand. | ☐ YES | ☐ NO | |
| 3. Post-deployment Health Assessment, PDHA, (DD Form 2796) completed and printed copy in medical record. Date _____ | ☐ YES | ☐ NO | |
| 4. Report of Medical Assessment (DD Form 2697) completed, signed and copy in medical record. Date _____ | ☐ YES | ☐ NO | |
| 5. Medical Readiness Review System (MRRS) updated. | ☐ YES | ☐ NO | ☐ N / A |
| 6. If indicated, TBI Survey completed. | ☐ YES | ☐ NO | ☐ N / A |
| 7. If indicated, ANAM completed. | ☐ YES | ☐ NO | ☐ N / A |
| 8. If indicated, NAVMED 6470/16, Radiation Risk Assessment completed. | ☐ YES | ☐ NO | ☐ N / A |
| **B. AUDIOGRAM** | | | |
| 1. If Service Member on hearing conservation, DD Form 2216 completed. Date _____ | ☐ YES | ☐ NO | ☐ N / A |
| **C. LABS** | | | |
| 1. Serum Samples/HIV draws (Code H). Date _____ | ☐ YES | ☐ NO | |
| 2. If labs ordered by provider, are results documented in medical record? Date _____ | ☐ YES | ☐ NO | |
| 3. Screening for Hepatitis C antibodies completed (per MANMED Chapter 15, Article 21.) Date _____ | ☐ YES | ☐ NO | |
| **D. MEDICATIONS** | | | |
| 1. Service Member advised regarding terminal malaria prophylaxis? Date _____ | ☐ YES | ☐ NO | ☐ N / A |
| 2. If indicated, does Service Member have terminal malaria prophylaxis medication in hand? | ☐ YES | ☐ NO | ☐ N / A |
| 3. Does Service Member have 90 days of required prescribed medication? | ☐ YES | ☐ NO | ☐ N / A |

NOTES:
1. Malaria terminal prophylaxis: Medical providers shall follow most current DoD, Navy Medicine and/or COCOM Individual Protection and Individual/Unit Deployment AOR specific policy recommendations.
2. Medications:
   A. Service Members are eligible to receive a 90 day supply of all required medications upon redeployment/demobilization.
   B. Service Members requiring ongoing pharmacotherapy are encouraged to use the mail-order pharmacy system. Ensure mailing and e-mail addresses updated for Tricare Mail Order Pharmacy (TMOP) Program via https://member.expressscripts.com/web/member/loginreg/dodLoginStart.do prior to requesting refills or new prescriptions.
   C. Contact Pharmacy Operations Center at 1-866-ASK4PEC (866-275-4732) for any pharmacy related benefit questions.

**E. COMMENTS ON SHADED AREA RESPONSES** *(Include line number)*

| Service Member Name *(Last, First, MI)* | Rate / Rank | SSN |
|---|---|---|
| | | |

**PART II - MEDICAL PROVIDER SCREENING**

**A. MEDICAL SCREENING FOR ALL REDEPLOYERS**

In addition to this form, Service Members returning from Overseas Contingency Operations Support Assignments (OSA) will complete the following DoD forms:

DD Form 2697, Report of Medical Assessment.
DD Form 2796, Post-Deployment Health Assessment Questionnaire (within 30 days of redeployment).
DD Form 2807-1, Report of Medical History (if indicated per MANMED Chapter 15, Article 21).
DD Form 2900, Post-Deployment Health Re-Assessment (PDHRA) (within 90-180 days upon return from deployment at parent command).

| | | | |
|---|---|---|---|
| 1. Provider review of theater deployment medical documentation (AHLTA-T or other medical documentation). | ☐ YES | ☐ NO | |
| (a) Have all new medical conditions been identified and addressed? | ☐ YES | ☐ NO | |
| (b) Has Service Member been medically evacuated (medevac) while in theater of operations? | ☐ YES | ☐ NO | |
| (c) If Laboratory tests are indicated, results reviewed and documented in medical record? | ☐ YES | ☐ NO | |
| (d) If medical referrals indicated, AHLTA entry completed? | ☐ YES | ☐ NO | |
| 2. Provider review DD Form 2796 (PDHA)? | ☐ YES | ☐ NO | |
| (a) Has entry been completed in MRRS deployment module? | ☐ YES | ☐ NO | |
| (b) Are medical referrals indicated? (If YES, ensure AHLTA entry, and comments in Section II D.) | ☐ YES | ☐ NO | |
| (c) If medical referral initiated, is MRRS deployment module updated? | ☐ YES | ☐ NO | |
| 3. Provider medical entry completed in AHLTA with copy in medical record? | ☐ YES | ☐ NO | |

**B. RESERVE COMPONENT (RC) ADDITIONAL REDEPLOYMENT MEDICAL SCREENING**

| | | | |
|---|---|---|---|
| 1. Has Service Member been cleared by medical provider to demobilize? | ☐ YES | ☐ NO | |
| 2. Has Service Member received separation physical examination for identified medical condition(s)? | ☐ YES | ☐ NO | |
| (a) If indicated, has DD Form 2807-1 been completed? | ☐ YES | ☐ NO | |
| (b) If indicated, has medical referral been completed and placed in medical record? | ☐ YES | ☐ NO | |
| 3. Does Service Member have a medical condition which requires placement in Medical Evaluation Status? | ☐ YES | ☐ NO | |
| 4. Has Service Member been placed on Medical Hold status? | ☐ YES | ☐ NO | |
| 5. Has member been placed in Line of Duty (LOD) status? | ☐ YES | ☐ NO | |

**C. COMMENTS ON SHADED AREA RESPONSES** *(Include line number)*

**D. MEDICAL PROVIDER**

| 1. Name | 2. Rank / Grade | 3. Corps | 4. MTF or Duty Station |
|---|---|---|---|
| | | | |

| 5. Telephone Number *(Include Area Code)* | 6. DSN | 7. Facsimile Number *(Include Area Code)* |
|---|---|---|
| | | |

| 8. E-Mail Address | 9. Signature | 10. Date |
|---|---|---|
| | | |

| Service Member Name *(Last, First, MI)* | Rate / Rank | SSN |
|---|---|---|
| | | |

**PART III - DENTAL PROVIDER SCREENING**

**A. SCREENING**

| | | | |
|---|---|---|---|
| 1. Dental Record in hand. | ☐ YES | ☐ NO | |
| 2. Service Member is dental class 1 or 2. Exam Date _____ | ☐ YES | ☐ NO | |
| 3. MRRS Updated. | ☐ YES | ☐ NO | |
| 4. DD Form 214 reflects updated dental status. | ☐ YES | ☐ NO | |
| 5. RC ONLY: Dental Examination completed. Date _____ | ☐ YES | ☐ NO | |

Note: (RC ONLY) Service Member has 180 days from separation date to complete identified dental requirements.

**B. COMMENTS ON SHADED AREA RESPONSES** *(Include line number)*

**C. DENTAL PROVIDER**

| 1. Name | 2. Rank / Grade | 3. Corps | 4. MTF or Duty Station |
|---|---|---|---|
| 5. Telephone Number *(Include Area Code)* | 6. DSN | | 7. Facsimile Number *(Include Area Code)* |
| 8. E-Mail Address | 9. Signature | | 10. Date |

**PART IV - FINAL REVIEW OF CERTIFICATION**

**A. SERVICE MEMBER**

My signature on this form certifies that I have read the form completely, that I agree with its contents, and that I have fully disclosed to the medical and dental officers in Parts I - III all medical conditions known to me at this time. Failure to fully disclose all of my medical conditions may result in disciplinary or administrative action under the UCMJ and may also result in the denial of treatment.

| a. Name | b. Rank / Rate | c. Signature | d. Date |
|---|---|---|---|
| | | | |

**B. COMMANDING OFFICER OR DESIGNEE**
(Includes OIC/CO Designee, Reserve Unit CO/Designee)

| 1. Name | 2. Rank / Grade | 3. Command or Duty Station |
|---|---|---|
| 4. Telephone Number *(Include Area Code)* | 5. DSN Number | 6. Facsimile Number *(Include Area Code)* |
| 7. E-Mail Address | 8. Signature | 9. Date |

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