

**Name:**  
**Current Duty Station:**  
**Phone Number:**

**RANK:**

**SSN:**  
**Next Duty Station:**

**Age:**

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## MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

**Privacy Act Statement**

**Authority:** 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).

**Purpose:** To identify special, medical, dental or educational needs for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.

**Routine uses:** This form is completed by a medical treatment facility (MTF)/non-MTF dentist and physician, nurse practitioner, physician assistant, or independent duty corpsman (Service members only). An MTF Medical Screener must counter sign all screenings completed by non-Navy MTF Providers. The MTF Suitability Screening Coordinator (SSC) will place the completed original form in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit.

**Disclosure:** Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2B for implementing guidance. **Complete one form for each Service and family member screened.**

<b>SERVICE MEMBER NAME</b>	<b>GRADE / RATE</b>	<b>AGE</b>	<b>SSN</b>
<b>FAMILY MEMBER NAME</b>	<b>FAMILY MEMBER PREFIX</b>	<b>AGE</b>	<b>SSN</b>
<b>NEXT DUTY STATION LOCATION &amp; UNIT IDENTIFICATION CODE (UIC):</b>		<b>TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only)</b>	

### PART I

**SECTION A. Medical Screening.** Completed by the medical provider to identify special needs and determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment. *Attach the completed Report of Medical History (DD 2807-1) to this form.*

Yes	No	N/A	ITEM
			1. All current health records (military and civilian) reviewed?
			2. All physical exams (to include special duty, aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? a. <i>Type of Physical</i> _____ b. <i>Completion date of physical</i> _____
			3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
			4a. Immunizations are up-to-date and meet destination country requirements?
			4b. Has the individual elected to decline any ACIP recommended immunizations or country required Immunizations? If yes (circle): ACIP Country Specific Date Counseled: _____
			5. Reference audiogram documented on DD 2215?
			6. Latest audiogram (DD 2216) reviewed?
			7. HIV testing completed or drawn?
			8. DNA testing completed and documented?
			9. Are there pending consults or tests that have a bearing on assignment suitability?
			10. Any past limited duty or medical board(s)? ( <i>document on DD 2807-1</i> )
			11. For Service members:
			a. Annual periodic health assessment current and documented?
			b. Pregnancy screening (verbal inquiry)? ( <i>Also, Command will refer for pregnancy test 30 days prior to departure date</i> )
			c. If pregnant? (EDC: _____ )
			12. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented?
			13. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			14. Are there any conditions requiring ongoing care in the following areas? ( <i>document on DD 2807-1</i> )
			a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
			b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
			c. Gynecologic/Urologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass)
			d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy)
			e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)
			f. Mental health or behavioral conditions (e.g., mood, personality disorder, ADD/ADHD, anxiety, psychosis, autism)
			g. Recurrent or frequent medications not on the standard formulary or require special attention (e.g., injections/infusions every 6-12 months, medication requiring Risk Evaluation and Mitigation Strategies per FD regulations, hormone replacement therapy, or medications requiring close monitoring of therapeutic blood level)? ( <i>list on DD 2807-1</i> )
			h. Alcohol or substance abuse or dependence
			i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
			j. Specify other conditions or concerns:
			15. For Service/family members requiring medication.
			a. Does the patient's medication maintenance require a dose adjustment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Are there concerns about medication management capabilities at the gaining MTF/operational platform if the underlying condition is exacerbated?
			d. Has the service/family member registered with the mail order pharmacy program through TRICARE?

Yes	No	N/A	ITEM
			16. For service/family members with underlying medical conditions:
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? (document on DD 2807-1)
			d. Are there any potential environmental concerns or possible health effects at the gaining location? (if yes, communicate to family and document on appropriate SF 600)
			17. For infants and toddlers (birth to 36 months), is the child receiving or undergoing eligibility to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			18. For preschool and school age children, is the child receiving or undergoing eligibility to receive special education and/or related services as evidenced by an Individualized Education Program (IEP)?
			19. Explanation of "yes" responses in shaded boxes (include #):  Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? Specify below:  Navy MTF SSC Name, Signature, Stamp, and Date: _____

**Non-Navy Medical Providers: STOP and proceed to SECTION C**

**SECTION B. Medical and Educational Screening Disposition.** Completed by the screening Navy MTF medical provider to determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment.

Yes	No	ITEM
		1. Are any of the above shaded blocks in Section A checked? If "yes", submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local capabilities to provide required support. (Attach Reply and answer questions 1a and 1b.) If "no", proceed to question 2.
		a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.)
		b. Does the gaining location have the capabilities to provide the required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated? (To include all Service MTFs/operational platform, TRICARE, etc.)
		2. Is the shaded block of question 18 checked "yes"? If yes, Submit the DD 2792-1 and IEP to the gaining DoDEA Special Education Overseas Screening Coordinator and gaining MTF to determine local capabilities to provide required support. (Attach Reply with POC info and answer question 2a.) If no, proceed to question 3.
		a. Is the DoDEA Special Education Overseas Screening Coordinator recommending travel?
Yes	No	<b>3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (Must be completed by an MTF medical screener. Answered after the inquiry is completed.)</b>

**SECTION C. Contact Information.** Completed by the MTF/non-MTF civilian providers who completed PART I. The Navy MTF medical screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Medical Screener (Signature) _____ Date _____  Printed Name, Rank or Grade _____  MTF or Duty Station _____  Telephone Number (include area/country code) _____  DSN Number _____  Office Hours to contact _____  E-mail Address _____	Non-Navy MTF/Civilian Medical Screener (Signature) _____ Date _____  Printed Name _____  Address _____  City, State, and Zip Code _____  Telephone Number (include area/country code) _____  Office Hours to Contact _____  E-mail Address _____
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**PART II**

SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN
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**SECTION A. Dental Screening.** Completed by a dental officer/privileged dentist prior to an overseas, remote duty, or operational assignment for the purpose of assessing and matching the dental needs of a service/family member to the support capabilities of the gaining medical treatment facility. **NOTE: If child does not have teeth -AND- is under the age of 24 months, a pediatrician may perform an oral dental screening.**

Yes	No	ITEM
<input checked="" type="checkbox"/>		1. All current dental records (military and civilian) reviewed?
<input checked="" type="checkbox"/>		2. All dental examinations are current? (If more than 180 days since last T-1 or T-2 dental exam, a dental officer/privileged dentist must, at a minimum, review the dental record and interval medical and dental history.)
	<input checked="" type="checkbox"/>	3. Is a reexamination required by a Navy MTF if examined or treated at a non-Navy facility?
N/A		4. If service/family member is in Dental Class 3 or 4, can dental treatment or examination be completed before the transfer?
	<input checked="" type="checkbox"/>	5. Is there a requirement for follow-on care such as orthodontics, implants, specialty prosthetics, etc.?
	<input checked="" type="checkbox"/>	6. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care?
	<input checked="" type="checkbox"/>	7. Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? <i>Specify below:</i>  Navy MTF SSC Name, Signature, Stamp, and Date: _____

8. Specify Dental Class: *(required for service members)* \_\_\_\_\_  
**Dental Classifications:** (Per DoDI 6025.19)  
**Normally considered worldwide deployable:**  
**Class 1** - Patients with a current dental examination, who do not require dental treatment or re-evaluation.  
**Class 2** - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.  
**Normally not considered worldwide deployable:**  
**Class 3** - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.  
**Class 4** - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

**SECTION B. Dental Screening Disposition.** Completed by the screening MTF provider to determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. **Non-Navy Medical Providers: STOP and proceed to SECTION C.**

Yes	No	ITEM
	<input checked="" type="checkbox"/>	1. Are any of the above shaded blocks checked? If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. <i>(Attach Reply and answer question 2)</i> If no, proceed to question 3.
<input checked="" type="checkbox"/>		2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<b>3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? (Must be completed by an MTF dental screener. Answered after the inquiry is completed.)</b>

**SECTION C. Contact Information.** Completed by the MTF/non-MTF civilian providers who completed PART II. The Navy MTF dental screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Dental Screener (Signature) _____ Date _____  Printed Name, Rank or Grade <b>NMRTC Lemoore</b>  MTF or Duty Station <b>559-998-4220</b>  Telephone Number (include area/country code)  DSN Number _____  Office Hours to Contact _____  E-mail Address _____	Non-Navy Medical Facility/Civilian Dental Screener (Signature) _____ Date _____  Printed Name _____  Address _____  City, State, and Zip Code _____  Telephone Number (include area/country code) _____  Office Hours to Contact _____  E-mail Address _____
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## MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14D authorizes collection of this information. The following information and documents, as applicable, are required to conduct medical, dental, and educational screening to determine suitability for an overseas, remote duty, or operational assignment. Complete and current information is essential for completion of screening. Disclosure is voluntary, however, missing or incomplete information may delay the screening process, result in orders held in abeyance until completion of screening, or affect the amount of leave in transit. Refer to BUMEDINST 1300.2B for implementing guidance.

The Suitability Screening Coordinator (SSC) at the military treatment facility (MTF) can assist in obtaining and completing the required information. The SSC will ensure required information and documents are complete and current before referral to a MTF provider for screening and a suitability recommendation. The SSC will place the completed original from in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit. Medical, dental, and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in the medical, dental, or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charge of any change in status (including pregnancy).  
*Complete one form for each Service and family member screened.*

SERVICE MEMBER NAME	GRADE/ RATE	SSN
CURRENT UNIT	TELEPHONE NUMBER	
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC)	TYPE DUTY CLASSIFICATION CODE (Navy Enlisted Code Only)	
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	Age
ITEM		SSC Review
<b>A. FOR SERVICE MEMBERS:</b>		YES   NO   N/A
<input type="checkbox"/>	1. Legible copy of orders or an Overseas Screening Notification. (For operational assignments, orders should indicate the platform to which assigned and a description of the duty assignment.)	
<input type="checkbox"/>	2. Each family member name, family member prefix, social security number, address and telephone number, if other than the service member's.	
<b>SERVICE TREATMENT RECORD TO INCLUDE:</b>		
<input type="checkbox"/>	3. All Physical Exams (to include special duty aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? a. Type of Physical _____ b. Completion Date of Physical _____	
<input type="checkbox"/>	4. Annual Periodic Health Assessment (PHA) current and documented?    Date: _____	
<input type="checkbox"/>	5. Current medical history (DD Form 2807-1)	
<input type="checkbox"/>	6. Hearing (Audiogram)	
<input type="checkbox"/>	7. Vision Examination	
<input type="checkbox"/>	8. G-6P-D Test	
<input type="checkbox"/>	9. PPD Test	
<input type="checkbox"/>	10. Sickle Cell Trait Test	
<input type="checkbox"/>	11. Negative HIV results current to 1 year of transfer Date Drawn: _____ Roster Number: _____	
<input type="checkbox"/>	12. Blood Type: _____	
<input type="checkbox"/>	13. DNA Testing completed and documented?	
<input type="checkbox"/>	14. Required Immunizations (Assignment Specific)	
<input type="checkbox"/>	15. Military Dental Records	
<input type="checkbox"/>	16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.	
<input type="checkbox"/>	17. Mammogram current and documented.    Date: _____	
<input type="checkbox"/>	18. Pregnancy screen (verbal inquiry). (Also, command will refer for pregnancy test 30 days prior to departure date.)	
<input type="checkbox"/>	Other:	
<b>B. FOR FAMILY MEMBERS:</b>		
<input type="checkbox"/>	1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1	
<input type="checkbox"/>	2. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. Include a completed DD Form 2807-1	
<input type="checkbox"/>	3. Recommended ACIP and required country specific immunizations (check current country specific immunization requirements issued by the Centers for Disease Control and Prevention (CDC) i.e. yellow fever)	

ITEM		SSC Review		
<b>C. FOR DEPENDENT CHILDREN:</b>		YES	NO	N/A
<input type="checkbox"/>	1. DD FORM 2792-1 (Required for ALL children birth to 22 <sup>nd</sup> Birthday OR High School Graduation)			
FOR INFANTS AND TODDLERS (Birth to 36 Months) ELIGIBLE TO RECEIVE EARLY INTERVENTION SERVICES AS EVIDENCED BY AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):				
<input type="checkbox"/>	2. Copy of the current IFSP and, if available, developmental assessments or evaluations.			
FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22 <sup>nd</sup> Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):				
<input type="checkbox"/>	3. Copy of the current IEP and, if available, developmental assessments or evaluations.			
FOR EACH FAMILY MEMBER ENROLLED OR UNDERGOING ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP):				
<input type="checkbox"/>	4. Copy of the DD Form 2792 and any EFMP correspondence.			
<b>D. FOR SSC USE ONLY</b>				
1. Date suitability screening conducted. Date: _____				
<b>E. SUITABILITY INQUIRY:</b>				
<input type="checkbox"/>	1. Are any of the shaded blocks checked on NAVMED Form 1300/1? <input type="checkbox"/> YES (Suitability Inquiry required, proceed to question 2) <input type="checkbox"/> NO (Line through question 2 and proceed to section F)			
<input type="checkbox"/>	2. Suitability Inquiry:			
	Medical Care:	Date & Time sent: _____	Reply date & time: _____	
	<input type="checkbox"/> Potential need identified	Sent by (Sending SSC): _____	Reply from: _____	
	<input type="checkbox"/> N/A	Sent to (Gaining SSC): _____	Contact #: _____	
			E-Mail: _____	
	Dental Services:	Date & Time sent: _____	Reply date & time: _____	
	<input type="checkbox"/> Potential need identified	Sent by (Sending SSC): _____	Reply from: _____	
	<input type="checkbox"/> N/A	Sent to (Gaining SSC): _____	Contact #: _____	
			E-Mail: _____	
	Special Education Services:	Date & Time sent: _____	Reply date & time: _____	
	<input type="checkbox"/> Potential need identified	Sent by (Sending SSC): _____	Reply from: _____	
	<input type="checkbox"/> N/A	Sent to (Gaining SSC): _____	Contact #: _____	
			E-Mail: _____	
		Sent to (Gaining DoDEA): _____	E-Mail: _____	
Other information:				
<b>F. SUITABILITY SCREENING COORDINATOR: Facility</b> _____, _____				
Printed Name: _____		Signature		Date
E-mail: _____				
Phone: _____				