

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	DOD ID
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

A. FOR SERVICE MEMBERS:

	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.			
SERVICE TREATMENT RECORD TO INCLUDE:			
<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. FOR FAMILY MEMBERS:

<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		
C. FOR DEPENDENT CHILDREN:		YES	NO	N/A
<input type="checkbox"/>	1. DD FORM 2792-1 (Required for ALL children birth to 22 nd 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 nd 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.			
D. FOR SSC USE ONLY				
1. Date suitability screening conducted. Date: _____				
E. SUITABILITY INQUIRY:				
<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:				
F. SUITABILITY SCREENING COORDINATOR: Facility:				
Printed Name: _____		Signature		Date
E-mail: _____				
Phone: _____				