FM 4-02.19
July 2009

DENTAL SERVICE SUPPORT OPERATIONS

Headquarters, Department of the Army

Field Manual
No. 4-02.19

Headquarters
Department of the Army
Washington, DC, 31 July 2009

Dental Service Support Operations

Contents

***This publication supersedes FM 4-02.19 dated 1 March 2001.**

Figures

Tables

Preface

This field manual (FM) provides doctrinal guidance for the employment of dental units conducting dental service support missions. The manual is intended for use by medical and nonmedical unit commanders and their staffs.

This manual has been completely revised and sequenced in order to achieve a more concise document with an improved flow of information. The focus is to provide discussion of the dental service support mission, the organization of medical/dental units, and the conduct of dental service support operations.

The staffing and organizational structures and positions presented in this manual reflect Medical Force 2000, Medical Reengineering Initiative, and Army transformation organizations established in tables of organization and equipment (TOEs). These tables were current at the time this manual was published. The organization of these units is subject to change in order to comply with manpower requirements criteria outlined in Army Regulation (AR) 71-32. These organizations are also subject to change at the unit level in order to meet wartime requirements and changes are reflected in the units' modified table of organization and equipment.

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) International Standardization Agreements (STANAGs):

NATO STANAG	TITLE
2014	Formats for Orders and Designation of Timings, Locations and Boundaries
2068	Emergency War Surgery
2122	Medical Training in First-Aid, Basic Hygiene and Emergency Care
2931	Orders for the Camouflage of the Red Cross and the Red Crescent on Land in Tactical Operations

This publication applies to the Active Army, the Army National Guard (ARNG)/Army National Guard of the United States (ARNGUS), and the U.S. Army Reserve (USAR) unless otherwise stated.

The proponent of this publication is the United States (U.S.) Army Medical Department Center and School (USAMEDDC&S). Send comments and recommendations in a letter format directly to the **Commander, USAMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052** or at e-mail address: Medicaldoctrine@amedd.army.mil. All recommended changes should be keyed to the specific page, paragraph, and line number. A rationale should be provided for each recommended change to aid in the evaluation of that comment.

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

The use of the term *continental United States (CONUS)* includes the continental U.S., Hawaii, Alaska, and its territories and possessions.

The use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

Chapter 1
Overview of Dental Service Support

SECTION I — IMPORTANCE OF ARMY DENTISTRY

MISSION

1-1. The mission of the Army Dental Care System is to provide Soldier-focused dental services in a timely and cost-effective manner that supports America's Army.

1-2. Stability operations, a part of full spectrum operations, are recognized in Department of Defense Directive 3000.05 and FM 3-0. As a result, the expanding mission of the Dental Corps includes supporting the main tenets of stability operations. For more detailed discussions refer to FM 3-0 and FM 8-42.

SOLDIER

1-3. The Soldier as the centerpiece of the U.S. Army is the basic guarantor of mission success. As such, his health and physical fitness are vitally important. Equally important is the Soldier's oral and dental health, which if not properly maintained can result in the Soldier becoming nondeployable and if already deployed, can render him nonmission-capable.

1-4. There are many reasons why a Soldier's oral and dental health can break down. This is especially true while a Soldier is deployed. There are a number of causes which can contribute to a decline in a Soldier's oral and dental health. Some of the more common causes include—

- Stress-induced compromise of the immune system.
- Inadequate oral and dental hygiene practices.
- Use of tobacco products.
- Accidental and combat-related injury to the face.

1-5. In addition to those considerations already listed, mission, enemy, terrain and weather, troops and support available, time available, civil considerations (METT-TC) may also present situations where Soldiers will not have ready access to a dental treatment facility (DTF) when routine dental care may be all that is required to correct a minor problem before it becomes more serious.

1-6. Review of past U.S. military deployments suggests that the longer a deployment lasts the more likely a Soldier is to experience a dental emergency. The same review also indicates that as a deployment lengthens there are fewer opportunities and resources available to enhance, maintain, and improve a Soldier's dental health. It is for these reasons that dental service support assets are organic to maneuver and movement units of the Army.

1-7. Although the primary focus of this publication is dental service support provided in theater, it is important to understand that the emphasis on a Soldier's oral and dental health begins at the time that he enters the Army and continues throughout his service commitment.

IMPACT OF DENTAL EMERGENCIES ON UNIT READINESS

1-8. Historically, 20 to 25 percent of all deployed Soldiers have experienced a dental emergency during a one-year deployment. The significance of this statistic is the potential impact on a unit's ability to execute its mission. The following examples are provided:

- During World War II, specifically 1943, the greatest numbers of Soldier complaints were in regard to the lack of adequate dental support.
- During the Korean War, 133,720 dental visits were recorded. These visits resulted in 493,441 dental procedures being performed.
- During the Vietnam War, dental emergencies for deployed U.S. Navy and U.S. Marine Corps personnel averaged 200 dental emergencies per one thousand Sailors and Marines deployed per year.
- During deployment processing for Operation Desert Shield over 150,000 Army National Guard and Reserve Component Soldiers were processed through DTFs in the CONUS. Over 40,500 of these Soldiers required panographic x-rays and 33,000 required dental treatments to be classified as deployable. The result was a mobilization system that was severely stressed and its ability to quickly process Soldiers for deployment was degraded.
- A review of the 12th Evacuation Hospital patient treatment records during Operation Desert Shield and Operation Desert Storm indicated that approximately 14 percent of Soldiers reporting for sick call were seen for dental emergencies. Once a detailed analysis of the information was completed the percentage of dental emergencies was actually found to be higher than 14 percent.
- Mobilization and deployment dental processing during Operation Desert Shield and Operation Desert Storm was provided to 243,829 DOD personnel between 2 August 1990 and the end of the war. Five reserve dental units and a number of individual mobilization augmentees were activated to help with the massive dental workload brought on by reserve force mobilization. This period also saw the stateside dental capability depleted by deployment of Active Army dental personnel.

1-9. The examples in paragraph 1-8 provide us with valuable insight regarding the number of Soldiers that may require dental treatment during a lengthy deployment. They also illustrate that when dental care is not readily available and Soldiers must be evacuated for treatment of dental emergencies, those Soldiers may be separated from their units for extended periods of time.

1-10. Based on the information provided above, it is easy to conclude that good oral and dental health is a force multiplier and that ready access to dental care can contribute significantly to unit readiness and morale.

SECTION II — ARMY DENTAL READINESS

DENTAL READINESS

1-11. Dental readiness refers to a Soldier's dental health as it relates to his worldwide deployment status. Dental readiness is fundamental to maintaining unit readiness and reducing noncombat dental casualties during deployments. Community oral health protection emphasizes not only oral health, but also general wellness and overall fitness of our Soldiers and all authorized beneficiaries. Army Regulation 40-35 provides guidance for the development and conduct of dental readiness and community oral health protection programs for all authorized beneficiaries of the Army Dental Care System. It describes the Dental Readiness Program for Active Army Soldiers and other programs that benefit all members of the Army community.

1-12. Lessons learned from previous mobilizations indicate that—

- Little time is available for treatment of dental emergencies during mobilization and deployment operations.
- High levels of dental readiness and dental preparedness reduce mobilization dental processing and treatment time.
- Three to five days is the average length of time a Soldier is lost to his unit when he must be evacuated for dental emergencies.

1-13. Due to the potential impact that dental emergencies may have on a unit's readiness, preventive dentistry programs must be actively supported by leaders.

1-14. High levels of premobilization dental readiness significantly reduce the number of dental emergencies experienced by deployed Soldiers.

1-15. Unit commanders, leaders at every level, the Army Dental Care System, and the Soldier all share the responsibility for the dental readiness of the command.

1-16. The importance of dental readiness cannot be overstated. Failure to maintain high levels of dental readiness adversely impacts on the ability of units to quickly mobilize and deploy. Army dental service support-specific Generating Force operations are addressed in Appendix A.

DENTAL READINESS PROGRAM

1-17. The Dental Readiness Program provides methods developed to reduce the risk of Soldiers becoming noncombat-related dental casualties when such an event could jeopardize the success of the mission. Dental Readiness Program methods include—

- Annual dental examinations in order to determine the oral and dental fitness and classification of each Soldier in the command.
- Priority examinations and treatment appointments for Soldiers who are at high risk or who have not had recent dental examinations (dental Class 3 and dental Class 4).
- Monthly dental readiness reports to unit commanders that identify the dental risk profile of the unit.

DENTAL CLASSIFICATIONS

1-18. Every Soldier is assigned a dental classification based on the results of a thorough oral and dental examination. The classification is a dentist's best judgment of the state of a Soldier's oral and dental health and is used to determine the likelihood that a patient will experience a dental emergency during a deployment. Dental classification criteria are provided in Appendix B.

PROCEDURES

1-19. The dental records of every Active Army Soldier will be screened on arrival at a new permanent duty station.

- Active Army Soldiers inprocessing at their permanent duty stations whose dental records indicate that no examination has been performed within the previous 6 months or who are dental Class 3 or dental Class 4 must have a dental examination at the local DTF prior to completing their inprocessing procedures. Every effort will be made to achieve dental Class 1 or dental Class 2 for all inprocessing Soldiers prior to reporting to their unit.
- Soldiers whose records indicate they are in dental Class 1 or dental Class 2 will have their next annual dental examination scheduled no later than 13 months from the date of completion of their last dental examination and readiness classification.
- Every Soldier's record will also be screened to ensure a panographic x-ray is present and that it is of adequate quality for diagnostic/identification purposes. If no panographic x-ray is present, one will be taken and placed in the dental record. There is no time requirement on updating panographic x-rays; however, the existing images must accurately represent the current oral and dental condition of the Soldier.

1-20. Soldiers in basic training or advanced individual training are required to have a dental readiness examination. This is dependent on the absence of a dental emergency, the availability of time during the training cycle, and the ability of local DTF to schedule and examine these Soldiers. If no examination occurs at this time, they must be examined at their first permanent duty station immediately upon inprocessing.

1-21. Soldiers will have their dental readiness classification updated annually by a clinical examination. Soldiers who fail to receive a dental examination by the last day of the 13th month from the date of their last examination or dental readiness update are automatically classified as dental Class 4 and are then placed in a nondeployable status.

1-22. Appointments for dental treatment required to achieve a satisfactory dental readiness status are scheduled according to the Soldier's current dental classification.

- Soldiers in dental Class 1 require no treatment.
- Soldiers in dental Class 2 are counseled on their dental needs and every effort must be made to move that patient to dental Class 1.
- Soldiers in dental Class 3 will have the condition causing the potential dental emergency described in the narrative portion of their dental health record so they may be reclassified to dental Class 1 or dental Class 2 as soon as the condition is corrected. Personnel in dental Class 3 will receive expedited treatment to remove them from this unsatisfactory dental classification. The immediate goal of expedited treatment is to take care of the patients most urgent dental needs and to avoid a potential dental emergency.

1-23. Prior to a Soldier's reassignment to an overseas location, his dental treatment records will be screened. Soldiers listed as dental Class 3 or dental Class 4 will not be cleared for overseas movement until they receive the necessary dental treatment to place them in at least dental Class 2 or unless otherwise approved in accordance with Department of the Army (DA) Pamphlet (DA Pam) 600-81. Dental screening should be completed at least 7 days prior to their actual rotation date.

1-24. Soldiers in dental Class 3 and dental Class 4 normally are not to be deployed unless the mission dictates otherwise. In these circumstances, a waiver may be granted by the installation commander with a recommendation from a dental officer in the rank of colonel or above.

ORGANIZATIONAL RESPONSIBILITIES

1-25. Commanders are responsible for the dental readiness of the Soldiers assigned to their command. Commanders must establish and implement procedures that will ensure that their command meets dental readiness standards as required by the Dental Readiness Program. Commanders will make their personnel available for appointments and maintain surveillance over the program to ensure the following:

- The supporting unit's dental clinic is the sole custodian of all unit personnel dental records. Newly arriving Soldiers will turn in their dental records to dental personnel for initial screening.
- When outprocessing a duty station, Soldiers whose records indicate no examination in the previous 6 months or who are a dental Class 3 or dental Class 4 will have dental examinations prior to completing their outprocessing procedures. If a Soldier outprocesses without achieving dental Class 1 or dental Class 2, they must receive priority care at their next duty location for a dental examination and/or to eliminate the emergent dental care problem. The unit's executive officer and senior noncommissioned officer (NCO) will be notified to assure follow-up care through the supporting dental clinic.
- All Soldiers in the unit will report for annual dental examinations. The unit is responsible for providing current personnel rosters to the supporting dental facility. The DTF uses these rosters to verify that each Soldier's dental treatment record is on file.
  - The supporting dental clinic provides rosters to the unit through both the Medical Protection System and Corporate Dental Application at 60 days and again at 30 days prior to their Soldiers being listed as dental Class 4.
  - The unit ensures that Soldiers listed as dental Class 3 or dental Class 4 or who require an annual dental examination are available for examination. The units also establish policies and procedures for dealing with Soldiers who are in repeated noncompliance.
- Emphasis should be placed on ensuring that Soldiers being assigned to recruiting duty, full-time manning programs for the Reserve Component, Reserve Officers' Training Corps duty, and military assistance group or embassy duty are in dental Class 1 before departing for their new assignments.

- Emphasis must be placed on ensuring that Soldiers in early deployment forces are maintained in a dental Class 1 or dental Class 2 status.

1-26. Commanders of dental activities, dental clinic commands, and separate active Army dental units are responsible for assisting supported units in maintaining the readiness of Soldiers.

1-27. Dental activity/dental clinic commands/dental unit commanders are responsible for the following functions:

- Serve as dental readiness advisors to unit commanders to assure compliance with the goal of 95 percent dental readiness (dental Class 1 and dental Class 2 combined).
- Screen dental records of newly arrived Soldiers to establish their dental readiness classification.
- Assist unit commanders in the elimination of dental Class 3 and dental Class 4 ratings by timely unit notification and coordination of appointments. Rosters are delivered in person or made available electronically at 60 days and then again at 30 days prior to the Soldier's required annual examination date.
- Provide monthly updates to the unit or its supporting personnel activity on changes in each Soldier's dental classification and date of last dental examination.
- Conduct audits of dental records annually against the unit's Dental Readiness Program roster located in Corporate Dental Application.

ORAL HEALTH THREATS

1-28. The two common threats to a Soldier's oral health are chronic disease and oral and maxillofacial injury.

- Chronic diseases include ulcerative gingivitis, acute pericoronitis, and periodontal abscesses, all of which are known to become exacerbated during periods of fatigue, nutritional deficiencies, poor oral hygiene, and physical and psychological stress. Milder gingival and periodontal disease may also increase in incidence and severity.
- Oral and maxillofacial injuries may result from both battle injury and nonbattle injury in operational settings.

1-29. Oral infections, resulting from chronic disease or maxillofacial injury, can advance to life-threatening oropharyngeal fascial space infections or cavernous sinus thrombosis if inappropriately managed.

SECTION III — CATEGORIES OF DENTAL CARE

PREVENTIVE DENTISTRY

1-30. Although preventive dentistry is not technically a category of dental care it is an extremely important component of the dental program. The results of good preventive dental care practices are healthy teeth and gums and the absence of oral disease. Therefore, Soldiers who incorporated good preventive dental hygiene practices are far less likely to become dental casualties due to disease while deployed.

1-31. Preventive dentistry incorporates primary, secondary, and tertiary preventive measures taken to reduce or eliminate conditions that may decrease a Soldier's fitness to perform his mission and which could result in the Soldier being removed from his unit for treatment.

1-32. Individual preventive dental care practices include—

- Eating a balanced diet.
- Brushing and flossing of the teeth and gums on a regular basis.
- Abstaining from using tobacco products.

1-33. These measures can effectively prevent the development of tooth decay and oral disease. The application of fluoride and sealants combined with regular dental checkups and oral screenings can prevent tooth decay and identify oral disease at its most treatable stages.

1-34. Due to the potential impact that dental emergencies can have on unit readiness, preventive dentistry programs must be actively supported by leaders.

1-35. A Soldier's dental readiness is determined by a thorough examination of the mouth. The standards used to determine a Soldier's dental readiness and classification are outlined in the DOD Oral Health and Readiness Classification System (see Appendix B). The purpose of this classification system is to help commanders estimate how many of their Soldiers are likely to require treatment for dental emergencies during a deployment. Commanders can minimize personnel losses to treatment or medical evacuation by ensuring that as many Soldiers as possible are dental Class 1 or dental Class 2 prior to deployment.

OPERATIONAL DENTAL CARE

1-36. Dental care provided for deployed Soldiers in theater is referred to as operational dental care. Operational dental care consists of emergency dental care and essential dental care.

EMERGENCY DENTAL CARE

1-37. Emergency dental care is care designed to provide relief of oral pain, elimination of acute infection, control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulty), and treatment of trauma to teeth, jaws, and associated facial structures. It is considered the most austere form of dental care provided to deployed Soldiers who are engaged in tactical operations.

1-38. Since dentists are not assigned to Role 1 medical treatment facilities (MTFs), the battalion surgeon or physician assistant can provide limited emergency dental treatment until the patient can be seen by a dentist. Common examples of emergency treatments include—

- Simple extractions.
- Temporary fillings.
- Administration of analgesics.
- Administration of antibiotics.

ESSENTIAL DENTAL CARE

1-39. Essential dental care is generally considered the highest category of operational dental care available in the theater. Essential dental care includes dental treatments which are performed in order to prevent potential dental emergencies and maintain the oral fitness of Soldiers. Essential dental care enhances the individual Soldier's combat readiness and can prevent lost duty time. It is for these reasons that essential dental care is made readily available. Soldiers who are categorized as dental Class 2 (untreated oral disease) or dental Class 3 (potential dental emergencies) should receive essential care as soon as the tactical situation and availability of dental assets permit.

1-40. Emergency treatments performed by dental officers include—

- Definitive restorations.
- Minor oral surgery.
- Exodontic, periodontic, and prosthodontic procedures.

COMPREHENSIVE DENTAL CARE

1-41. Comprehensive dental care consists of any and all procedures which are required to restore an individual to optimal oral health, function, and esthetics. Due to the complexity of the procedures and the length of time generally required to perform them, comprehensive dental care is normally provided only in the CONUS-support base. When comprehensive dental care is made available in theater, it is usually reserved for Army Health System plans in which extended periods of reception, staging, onward movement, and integration in theater are anticipated. The dental assets providing this degree of dental care are located within Role 3 MTFs.

SECTION IV — ADDITIONAL WARTIME ROLES

MASS CASUALTY SCENARIOS

1-42. Dental personnel have the additional wartime role of augmenting medical personnel during mass casualty situations. Under these circumstances, dental officers may be called upon to augment and assist the medical staff of these facilities in treating the sick and injured.

1-43. Dental officers and personnel may be called upon to render assistance in the following areas:

- Surgical procedures.
- Forensic dental identification.
- Maxillofacial injury treatment.
- Soft tissue wound management.
- Chemical, biological, radiological, and nuclear (CBRN) casualty management.
- Orthopedic injury treatment.
- Initial burn treatment.
- Intravenous infusion techniques.
- Intubation of surgical patients and patients with compromised airways.
- Infection control and sterile techniques.

1-44. While the focus on additional wartime roles has generally been on the individual provider, collective use of the dental unit or its subordinate elements may also be appropriate when the situation requires a consolidated medical response.

VETERINARY DENTAL SUPPORT

1-45. An additional wartime role for dental personnel involves providing dental treatment for military working dogs. On those occasions when military working dogs require emergency dental care or treatment for injuries involving their teeth, Veterinary Corps officers may request the assistance of Dental Corps officers to treat these animals.

SECTION V — ELIGIBILITY DETERMINATION FOR DENTAL CARE

1-46. During interagency and multinational operations, common questions are: "Who is eligible for care in a U.S. Army-established MTF?" and "What is the extent of care authorized?" For a detailed discussion regarding eligibility determination for care refer to FM 4-02.

1-47. Numerous categories of personnel seek care in U.S. facilities that are located in austere areas where host nation civilian medical infrastructure is nonexistent or is not capable of providing adequate care. A determination of eligibility and whether reimbursement for services is required is made at the highest level possible and in conjunction with the supporting staff judge advocate. Additionally, the Department of State and/or military staff sections (such as the Assistant Chief of Staff, Civil Affairs [G-9]) may also be involved in the determination process. Each operation is unique and the authorization for care is based on appropriate U.S. and international laws, DOD directives and DOD instructions, ARs, doctrine, and standing operating procedures (SOPs). Other factors impacting on the determination of eligibility are command guidance, practical humanitarian and medical ethics considerations, availability of U.S. Army Health System assets (in relationship to the threat faced by the force), and the potential training opportunities for Army Health System forces.

1-48. Basic documents required for determining eligibility of beneficiaries include AR 40-400; FM 27-10; relevant sections of Title 10, United States Code; relevant DOD directives and DOD instructions; acquisition and cross servicing agreements; orders from higher headquarters; interagency agreements such as memorandum of understanding and memorandum of agreement; and appropriate multinational agency guidance for the specific operation. If contractor personnel are present, a copy of the relevant sections of

their contracts should be on file to delineate specific medical services to be rendered. Additionally, for contract workers, a point of contact for the contracting company and a point of contact for the administration of the contract should be maintained.

1-49. Finally, the political-military environment of the area of operations must be taken into account as the command and control headquarters and its higher headquarters develop the eligibility matrix. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name. Refer to FM 4-02 for an example of an eligibility matrix. If individuals arrive at the emergency medical service section of the MTF who are not included in the medical/dental support matrix, the MTF must always stabilize the individual first and then determine the patient's eligibility for care. The command point of contact for eligibility determinations should be contacted immediately. Further, care will be provided in accordance with the SOP pending eligibility determination. (For example, a host nation civilian presents himself at the gate and requests medical treatment. Although on the surface it may appear that he is not eligible for care, this determination can only be made after a medical assessment is completed by competent medical personnel. In some cases, the individual may have to be brought into the MTF to accomplish an adequate medical assessment. Conducting a medical assessment does not obligate the U.S. military to provide the full spectrum of medical care. Although it does obligate the MTF to provide immediate stabilization for life-, limb-, and eyesight-threatening medical conditions and to prepare the patient for evacuation to the appropriate civilian or national contingent MTF when the patient's medical condition permits.)

Note. Any individual requesting medical care should receive a timely medical assessment of his condition. Even though the individual is not eligible for treatment, life-, limb-, or eyesight-saving procedures warranted by the individual's medical condition are provided to stabilize the individual for transfer to the appropriate civilian or other nation MTF.

1-50. The MTF staff must be familiar with the medical care available in the area of operations from other sources. These could include multinational or host nation military (tactical and strategic) forces, nongovernmental organizations or international organizations such as the United Nations, and local civilian resources. When appropriate and by knowing the level and types of care available, the MTF staff can plan for the continued care of the patient after initial stabilization is provided in the U.S. MTF and the patient can be transferred to another facility for continued care.

1-51. It is essential that eligibility for medical care guidance is disseminated and understood by the chain of command and all civilians and military members of the deployed force. The Army Health System commander must be able to articulate the basic concepts for medical eligibility determinations. This means that he will need to condense them into simple, easily understood instructions and widely disseminate them through electronic means or other media (such as pocket-sized cards). As the chief planner for medical operations, the Army Health System commander must ensure that this information is contained in the appropriate operation plan and operation order and briefed to the appropriate senior leadership of the command.

SECTION VI — DETAINEE DENTAL OPERATIONS

CONCERNS AND ISSUES

1-52. The primary unique concern in detainee medical operations is security. Designing the placement and location of chairs and the clinic floor plan should be to increase emphasis on security within the theater internment facility rather than patient privacy. Equipment and supplies should be accounted for at all times. All instruments should be inaccessible to detainees. Detainees should be visible to guards at all times. Detainees should not have ready access to exits. When detainees are being treated, weapons assigned to the dental staff must be secured.

EXAMINATIONS

1-53. The initial screening examination of detainees is used to identify obvious swelling, trauma, abscess, excessive bleeding, and lesions.

- Screening is done as a *look-see*, which is completed by using a flashlight and tongue depressor.
- When one or more of the above are noted, the detainee should be brought to the dental clinic immediately for a more involved examination with x-rays and treatment, if necessary.
- Prescriptions are written as deemed necessary for the treatment of the detainee's dental condition.

1-54. Screening examination findings are recorded on Standard Form (SF) 603 (Health Record—Dental) and SF 603A (Medical Record—Dental-Continuation) and placed in the detainee's medical record which was initiated during the medical screening conducted when the detainee was inprocessed to the theater internment facility.

- Obvious findings recorded include extractions (such as root tips or nonrestorable caries), restorable caries, and partially impacted wisdom teeth.
- Detainees are asked if pain is involved and the response is noted.

TREATMENT SCREENING PROCEDURES

1-55. After detainees have been medically inprocessed to the theater internment facility, periodic screens may be required to intercept dental emergencies.

1-56. A specific detainee may be referred for dental evaluation and treatment from a number of areas. The procedure for requesting a specific detainee to report for dental evaluation and treatment is to provide a memorandum to the military police the night before, requesting the detainee report in the morning. The detainee can be referred by—

- Consults turned in from doctors.
- Medical inprocessing screens.
- Sick call.
- Follow-ups from the previous day.

1-57. When detainees come for treatment, the treatment is documented on a new SF 603 and SF 603A.

- The detainee's name and internment serial number is written in pen and his domicile location is entered in pencil as this may change.
- The SF 603 and SF 603A are maintained in the detainee's individual medical record. The medical record is requested from the supporting patient administration division, as required.

1-58. Evaluation and determination of required treatment consists of the following:

- The dentist and translator screen the detainee's medical history for any adverse reaction to previous dental treatment.
- The detainee is asked where and what kind of pain he is experiencing. This is documented on the SF 603 and SF 603A.
- Radiographs are taken of the teeth that the detainee has complained about. The dental officer determines whether other teeth need to be x-rayed that may require dental treatment.
- Once taken, the dentist is notified and reads the x-ray. The assistant is then told what type of treatment to setup for.
  - Detainees are informed through a translator of treatment required.
  - They have the opportunity to either accept or refuse treatment.
  - If treatment is refused, they are informed of the complications that may result from not having treatment and the refusal is noted in their dental records.

1-59. Detainees often do not get to eat breakfast before they come in the morning; therefore, the dental clinic maintains nutritional support drinks in the clinic, for those detainees who—

- Need to take pain medication immediately.
- Will have extensive oral surgery (several teeth taken out in one day).
- Are diabetic (given before receiving treatment).

1-60. Once the dental procedure is completed, if a—

- Prescription is required and subsequently written, it will include the detainee's name, internment serial number, and domicile location.
- Prescription for an immediate dose is written, the assistant will take it down to the pharmacy to have it filled.
- Prescription is written for the detainee to take later, this is indicated across the top and turned in to the pharmacy.

1-61. Once the detainee is finished with the dental procedure, the military police are asked to return the detainee to the compound, hospital ward, or holding cell as appropriate.

- Postoperative instructions are given through a translator.
- An immediate dose of medication is given (if required).

Note. Detainees are not permitted to keep medications on their person. After the initial medication is given in the clinic, other doses of the medication will be provided per established procedures in the theater internment facility SOP.

- The guard is asked to bring in the next detainee. For security reasons, a maximum number of detainees permitted in the clinic at one time is established. This is dependent upon the size of the area and the number of providers.
- Follow-up examinations will be requested as needed.

WEAPONS

1-62. Weapons belonging to staff members should not be allowed into the clinic area when detainees are being examined or treated. Weapons should be secured in predesignated areas in accordance with established policies and procedures. This will ensure that they are inaccessible to detainees.

TRANSLATORS

1-63. A translator is required during all dental treatment of detainees. The translator is required to assist the dental officer in ensuring the medical history is accurately reviewed, to inform the detainee of the procedures to be performed, and to translate the concerns of the detainee to the dental officer and of the dental officer to the detainee during treatment.

PHOTOGRAPHS

1-64. There are stringent regulations pertaining to the photographing of detainees. Medical photographs will only be used to document preexisting conditions and traumatic injuries and to provide a basis for justification of why treatment was performed. Any medical photographs taken become a part of the detainee's medical record.

SICK CALL AND EMERGENCIES

1-65. Dental emergencies (such as bleeding, externally expanding abscesses, pain, and trauma) are treated immediately after emergency room notification, dental evaluation, and confirmation of urgency.

HOSPITAL PATIENTS

Inpatients

1-66. Inpatients are treated on a per consult basis either at the bedside or in the clinic based on ambulatory capacity. All detainee inpatients must be under guard when leaving the ward and continuously while they are off the ward. Detainee inpatients cannot move within the facility or to the clinic unless under guard.

Dental Inpatients

1-67. Detainees admitted for reasons related to dental emergencies may be admitted by the emergency room physician per dental consult and emergency care required. Discharge is per mutual agreement between medical and dental staff.