

STP 8-91X14-SM-TG

# SOLDIER'S MANUAL AND TRAINER'S GUIDE



**MOS 91X  
MENTAL  
HEALTH  
SPECIALIST**  
SKILL LEVELS 1/2/3/4



**HEADQUARTERS, DEPARTMENT OF THE ARMY**

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**SOLDIER TRAINING PUBLICATION  
No. 8-91X14-SM-TG**

**HEADQUARTERS  
DEPARTMENT OF THE ARMY  
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**SOLDIER'S MANUAL  
SKILL LEVELS 1/2/3/4  
AND TRAINER'S GUIDE**

**MOS 91X  
MENTAL HEALTH SPECIALIST**

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**PREFACE**

This publication is for skill level 1, 2, 3, and 4 soldiers holding military occupational specialty (MOS) 91X and for trainers and first-line supervisors. It contains standardized training objectives, in the form of task summaries, to train and evaluate soldiers on critical tasks which support unit missions during wartime. Trainers and first-line supervisors should ensure soldiers holding MOS/SL 91X1/2/3/4 have access to this publication. It should be made available in the soldier's work area, unit learning center, and unit libraries.

This manual applies to both Active and Reserve Component soldiers.

The proponent of this publication is HQ, TRADOC. Send comments and recommendations on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Academy of Health Sciences, ATTN: MCCS-HTI (TLS), 1750 Greeley Road, STE 123, Fort Sam Houston, TX 78234-6122.

## CHAPTER 1

### INTRODUCTION

#### GENERAL

This manual identifies the individual MOS training requirements for soldiers in MOS 91X. Commanders, trainers, and soldiers should use it to plan, conduct, and evaluate individual training in units. This manual is the primary MOS reference to support the self-development and training of every soldier.

Use this manual with Soldier's Manuals of Common Tasks (STP 21-1-SMCT and STP 21-24-SMCT), Army Training and Evaluation Programs (ARTEPs), and FM 25-101, Battle Focused Training, to establish effective training plans and programs which integrate soldier, leader, and collective tasks.

#### SOLDIER'S RESPONSIBILITIES

Each soldier is responsible for performing individual tasks which the first-line supervisor identifies based on the unit's METL. The soldier must perform the tasks to the standards listed in the SM. If a soldier has a question about how to do a task or which tasks in this manual he or she must perform, it is the soldier's responsibility to ask the first-line supervisor for clarification. The first-line supervisor knows how to perform each task or can direct the soldier to the appropriate training materials.

#### NCO SELF-DEVELOPMENT AND THE SOLDIER'S MANUAL

Self-development is one of the key components of the leader development program. It is a planned progressive and sequential program followed by leaders to enhance and sustain their military competencies. It consists of individual study, research, professional reading, practice, and self-assessment. Under the self-development concept, the NCO, as an Army professional, has the responsibility to remain current in all phases of the MOS. The SM is the primary source for the NCO to use in maintaining MOS proficiency.

Another important resource for NCO self-development is the Army Correspondence Course Program (ACCP). Refer to DA Pamphlet 351-20 for information on enrolling in this program and for a list of courses, or write to: Commandant, Academy of Health Sciences, ATTN: MCCS-HSN, Fort Sam Houston, TX 78234-6199.

Unit learning centers are valuable resources for planning self-development programs. They can help access enlisted career maps, training support products, and extension training materials. An NCO career development model for CMF 91 soldiers can be found on pages 1-3 and 1-4. Recommended certification and degree goals for MOS 91X soldiers are on page 1-4.

## **TRAINING SUPPORT**

This manual includes the following information which provides additional training support information.

- Appendix A, DA Form 5165-R (Field Expedient Squad Book). This appendix provides an overprinted copy of DA Form 5165-R for the tasks in this MOS. The NCO trainer can use this form to set up the leader book described in FM 25-101, appendix B. The use of this form may help preclude writing the soldier tasks associated with the unit's mission essential task list, and can become a part of the leader book.
- Glossary. The glossary, which follows the last appendix, is a single comprehensive list of acronyms, abbreviations, definitions, and letter symbols.
- References. This section contains two lists of references, required and related, which support training of all tasks in this SM. Required references are listed in the conditions statement and are required for the soldier to do the task. Related references are materials which provide more detailed information and a more thorough explanation of task performance.

<b>CMF 91</b>		<b>THE FOLLOWING ARE ONLY RECOMMENDATIONS.</b> It may not be feasible to complete recommended courses since assignments may preclude off-duty education. Alternate methods of achieving CMF course recommendations are possible (correspondence courses, examinations, and ACE-recommended credits). See an education counselor for assistance in completing recommended courses/ goals.				
<b>NCO CAREER DEVELOPMENT MODEL</b>						
<b>DEVELOPMENTAL ASSIGNMENTS</b>						
<b>RANKS</b>	<b>PVT-PFC SPC/CPL</b>	<b>SGT</b>	<b>SSG</b>	<b>SFC</b>	<b>MSG</b>	<b>SGM/CSM</b>
<b>SKILL LEVELS</b>	10	20	30	40	50	
<b>DUTY ASSIGNMENTS</b>		Recruiter/Retention Drill SGT		Observer/Controller		
		Team Leader		Operations/Intel SGT		
		Squad Ldr	Platoon SGT SGL/Instructor		First SGT	
<b>INSTITUTIONAL TRAINING</b>						
	BCT/AIT PLDC	BNCOC	ANCOC	Battle Staff NCO Course/1SG Course	Sergeants Major Course	
<b>SELF-DEVELOPMENT</b>						
<b>RECOMMENDED NCOES-RELATED COURSES AND ACTIVITIES</b>	<b>PRIOR TO PLDC</b>	<b>PRIOR TO BNCOC</b>	<b>PRIOR TO ANCOC</b>			<b>PRIOR TO SMC</b>
	English Composition	Communication Skills	Principles of Management			Research Techniques (Statistics)
	Basic Mathematics	Personnel Supervision	Organizational Behavior			Human ResourceMangement
	Computer Literacy	Behavioral Science	Information Mgt Systems			
		Stress Management	Technical Writing			
		Fundamentals of Speech	Health & Fitness			
		Maintenance Management				
		Records Management				
	Recommended Reading Standard: 10 Achieve Writing Standard (DA Pam 600-67)			Recommended Reading Standard: 12 Achieve Writing Standard (DA Pam 600-67)		

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<b>SKILL LEVELS</b>	<b>10</b>	<b>20</b>	<b>30</b>	<b>40</b>	<b>50</b>
<b>RECOMMENDED CMF-RELATED COURSES AND ACTIVITIES</b>	Medical Terminology	Human Growth & Development	Social Psychology	Adult Education Course	Budget & Finance
	Biology	Abnormal/ Adolescent Psychology	Principles of Instruction	Organizational Management	Health Care Planning/ Administration
	Chemistry	Counseling		Accounting	Marketing
	Physics (42E)	Foreign Language	Organizational Management	Hospital Administration	ACCP Continued
	Anatomy & Physiology	Educational Psychology	Economics	Health Care Law	
	Psychology & Sociology	Comparative Anatomy	Human Relations	Health Care Planning	
	Typing/Intro to Keyboards	ACCP Continued	Medical/Legal Ethics	Basic SDATS	
	Foreign Language	Computer Courses	Management Strategy	ACCP Continued	
	Consult Supervisor for appropriate correspondence courses (ACCP) for next level		Leadership Management	Continue Computer Courses	
Problem Solving					
ACCP Cont					
Continue Computer Courses					
<b>RECOMMENDED CERTIFICATION</b>	<b>RECOMMENDED AA/AS/AAS DEGREE</b>		<b>RECOMMENDED BACCALAUREATE DEGREE</b>		
None.	AAS or AS in Behavioral Science. Complete 1 year college by 8th year of service. Accomplish degree by 11th year of service.		Baccalaureate degree commensurate with MOS specialty or Health Care Administration Management. Accomplish by 20th year of service.		

## CHAPTER 2

### TRAINER'S GUIDE (TG)

#### GENERAL

The TG identifies the essential components of a unit training plan for individual training. Units have different training needs and requirements based on differences in environment, location, equipment, dispersion, and similar factors. Therefore, the TG is a guide used for conducting unit training and not as a rigid standard.

The TG provides information necessary for planning training requirements for the MOS. The TG--

- Identifies subject areas in which to train soldiers.
- Identifies the critical tasks for each subject area.
- Specifies where soldiers are trained to standard on each task.
- Recommends how often to train each task to sustain proficiency.
- Recommends a strategy for cross-training soldiers.
- Recommends a strategy for training soldiers to perform higher level tasks.

#### BATTLE FOCUSED TRAINING

As described in FM 25-100, Training the Force, and FM 25-101, Battle Focused Training, the commander must first define the mission essential task list (METL) as the basis for unit training. Unit leaders use the METL to identify the collective, leader, and soldier tasks which support accomplishment of the METL. Unit leaders then assess the status of training and lay out the training objectives and the plan for accomplishing needed training. After preparing the long- and short-range plans, leaders then execute and evaluate training. Finally, the unit's training preparedness is reassessed, and the training management cycle begins again. This process ensures that the unit has identified what is important for the wartime mission, that the training focus is applied to the necessary training, and that training meets established objectives and standards.

#### RELATIONSHIP OF SOLDIER TRAINING PUBLICATIONS (STPs) TO BATTLE- FOCUSED TRAINING

The two key components of enlisted STPs are the Trainer's Guide (TG) and Soldier's Manual (SM). The TG and SM give leaders important information to help in the battle-focused training process. The TG relates soldier and leader tasks in the MOS and SL to duty positions and equipment. It provides information on where the task is trained, how often training should occur to sustain proficiency, and who in

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the unit should be trained. As leaders go through the assessment and planning stages, they should use the TG as an important tool in identifying what needs to be trained.

The execution and evaluation of soldier and leader training should rely on the Armywide training objectives and standards in the SM task summaries. The task summaries ensure that soldiers in any unit or location have the same definition of task performance and that trainers evaluate the soldiers to the same standard. The diagram on the following page shows the relationship between battle-focused training and the use of the TG and SM. The left-hand side of the diagram (taken from FM 25-101) shows the soldier training process while the right side of the diagram shows how the STP supports each step of this process.

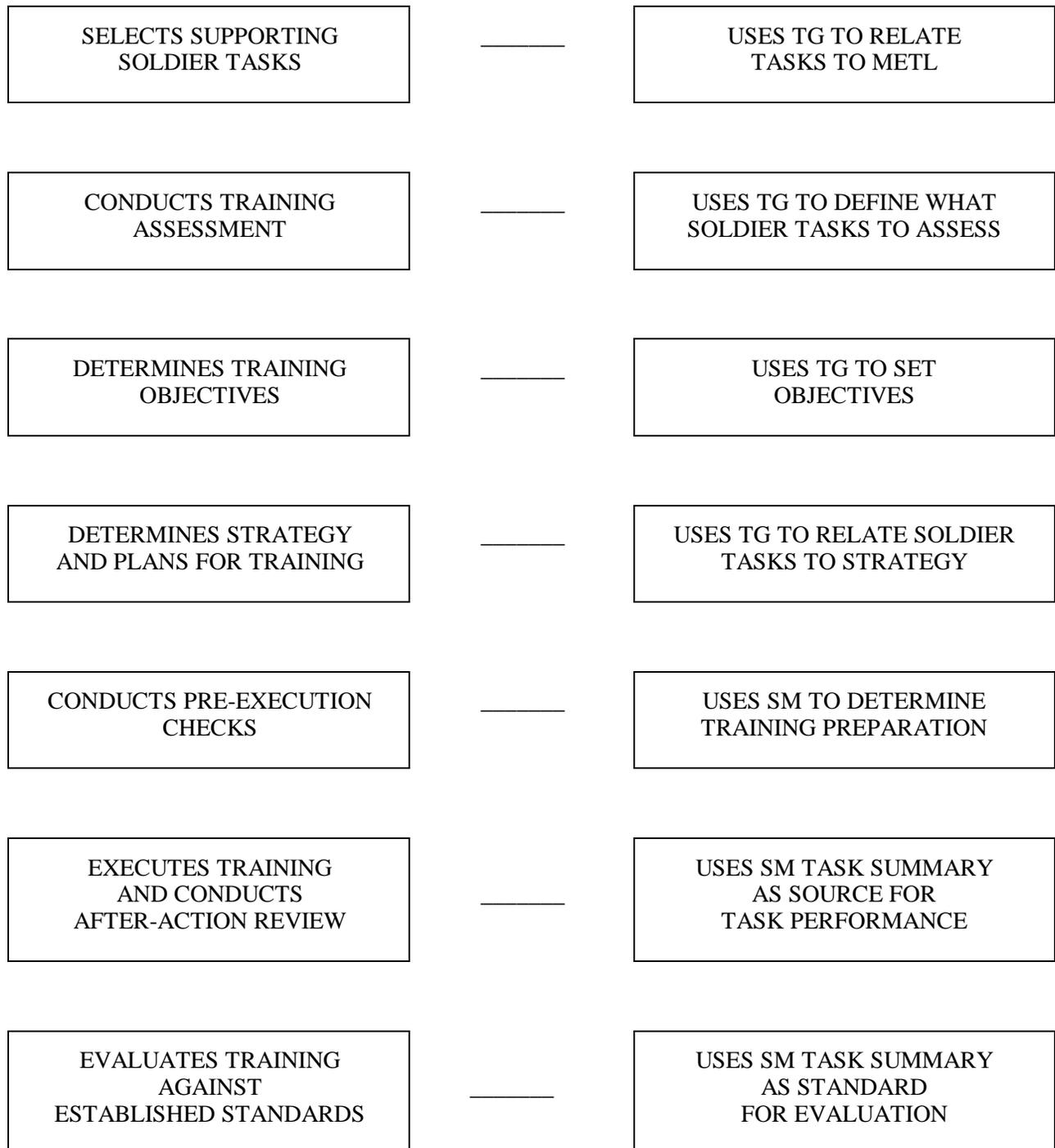
### **TRAINER'S RESPONSIBILITIES**

Training soldier and leader tasks to standard and relating this training to collective mission-essential tasks is the NCO trainer's responsibility. Trainers use the steps below to plan and evaluate training.

- Identify soldier and leader training requirements. The NCO determines which tasks soldiers need to train on using the commander's training strategy. The unit's METL and ARTEP and the MOS Training Plan (MTP) in the TG are sources for helping the trainer define the individual training needed.
- Plan the training. Training for specific tasks can usually be integrated or conducted concurrently with other training or during "slack periods." The unit's ARTEP can assist in identifying soldier and leader tasks which can be trained and evaluated concurrently with collective task training and evaluation.
- Gather the training references and materials. The SM task summary lists all references which can assist the trainer in preparing for the training of that task.
- Determine risk assessment and identify safety concerns. Analyze the risk involved in training a specific task under the current conditions at the time of scheduled training. Ensure that your training preparation takes into account those cautions, warnings, and dangers associated with each task.
- Train each soldier. Show the soldier how the task is done to standard, and explain step-by-step how to do the task. Give each soldier one chance to do the task step-by-step.
- Emphasize training in mission-oriented protective posture (MOPP) level 4 clothing. Soldiers have difficulty performing even the very simple tasks in a nuclear/chemical environment. The combat effectiveness of the soldier and the unit can degrade quickly when trying to perform in MOPP 4. Practice is the best way to improve performance. The trainer is responsible for training and evaluating soldiers in MOPP 4 so that they are able to perform critical wartime tasks to standards under nuclear/chemical environment.
- Check each soldier. Evaluate how well each soldier performs the tasks in this manual. Conduct these evaluations during individual training sessions or while evaluating soldier proficiency during the conduct of unit collective tasks. This manual provides an evaluation guide for each task to enhance the trainer's ability to conduct year-round, hands-on evaluations of tasks critical to the unit's mission. Use the

**BATTLE-FOCUS PROCESS**

**STP SUPPORT PROCESS**



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information in the MTP as a guide to determine how often to train the soldier on each task to ensure that soldiers sustain proficiency.

- Record the results. The leader book referred to in FM 25-101, appendix B, is used to record task performance and gives the leader total flexibility on the method of recording training. The trainer may use DA Forms 5164-R (Hands-On Evaluation) and 5165-R (Field Expedient Squad Book) as part of the leader book. The forms are optional and locally reproducible. STP 21-24-SMCT contains a copy of the forms and instructions for their use.

- Retrain and evaluate. Work with each soldier until he or she can perform the task to specific SM standards.

### **EVALUATION GUIDE**

An evaluation guide exists for each task summary in the SM. Trainers use the evaluation guides year-round to determine if soldiers can perform their critical tasks to SM standards. Each evaluation guide contains one or more performance measures which identify what the trainer needs to observe to score a soldier's performance. Each step is clearly identified by a "P" (Pass) and "F" (Fail), located under the "Results" column on each evaluation guide. Some tasks involve a process which the trainer must observe as the soldier performs the task. For other tasks, the trainer must evaluate an "end product" resulting from doing the task. The following are some general points about using the evaluation guide to evaluate soldiers:

- Review the guide to become familiar with the information on which the soldier will be scored.
- Ensure that the necessary safety equipment and clothing needed for proper performance of the job are on hand at the training site.
- Prepare the test site according to the conditions section of the task summary. Some tasks contain special evaluation preparation instructions. These instructions tell the trainer what modifications must be made to the job conditions to evaluate the task. Reestablish the test site to the original requirements after evaluating each soldier to ensure that conditions are the same for each soldier.
- Advise each soldier of the information in the Brief Soldier section of the task summary before evaluating.
- Score each soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the soldier must pass all performance measures to be scored GO. If the soldier fails any steps, show what was done wrong and how to do it correctly.
- Record the date and task performance ("GO" or "NO-GO") in the leader book.

## TRAINING TIPS FOR THE TRAINER

### 1. Prepare yourself.

- Get training guidance from your chain of command on when to train, which soldiers to train, availability of resources, and a training site.
- Get the training objective (task, conditions, and standards) from the task summary in this manual.
- Ensure you can do the task. Review the task summary and the references in the reference section. Practice doing the task or, if necessary, have someone train you on the task.
- Choose a training method.
- Prepare a training outline consisting of informal notes on what you want to cover during your training session.
- Practice your training presentation.

### 2. Prepare the resources.

- Obtain the required resources identified in the conditions statement for each task.
- Gather equipment and ensure it is operational.
- Coordinate for use of training aids and devices.
- Prepare the training site according to the conditions statement and evaluation preparation section of the task summary, as appropriate.

### 3. Prepare the soldiers.

- Tell the soldier what task to do and how well it must be done. Refer to the standards statement and evaluation preparation section for each task as appropriate.
- Caution soldiers about safety, environment, and security.
- Provide any necessary training on basic skills that soldiers must have before they can be trained on the task.
- Pretest each soldier to determine who needs training in what areas by having the soldier perform the task. Use DA Form 5164-R and the evaluation guide in each task summary to make this determination.

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4. Train the soldiers who failed the pretest.

- Demonstrate how to do the task or the specific performance steps to those soldiers who could not perform to SM standards. Have soldiers study the appropriate materials.

- Have soldiers practice the task until they can perform it to SM standards.

- Evaluate each soldier using the evaluation guide.

- Provide feedback to those soldiers who fail to perform to SM standards and have them continue to practice until they can perform to SM standards.

5. Record results in the leader book.

## **MILITARY OCCUPATIONAL SPECIALTY TRAINING PLAN**

One of the key components of the TG is the MOS Training Plan (MTP). The MTP has two parts to assist the commander in preparing a unit training plan which satisfies integration, cross-train, train-up, and sustainment training requirements for soldiers in this MOS.

### **PART ONE**

Part one of the MTP shows the relationship of an MOS SL between duty position and critical tasks. The critical tasks are grouped by task commonality into subject areas. Section I lists subject area numbers and titles used throughout the MTP. Section II defines the training requirements for each duty position within an MOS and relates duty positions to subject areas and cross-training and train-up/merger requirements.

- Duty position column--contains the MOS duty positions, by skill level, which have different training requirements.

- Subject area column--lists by subject area number, the subject areas in which the soldier must be proficient for that duty position.

- Cross-train column--lists the recommended duty position for which soldiers should be cross-trained.

- Train-up/merger column--lists the corresponding duty position for the next higher SL or MOS the soldier will merge into on promotion.

### **PART TWO**

Part two lists by subject areas, the critical tasks to be trained in an MOS, task number, task title, location, sustainment training frequency, and training SL.

- Subject area column--lists the subject area number and title in the same order as in the MTP, Part One, Section I.

- Task number column--lists the task numbers for all tasks included in the subject area.
- Task title column--lists the task title.
- Training location column--identifies the training location where the task is first trained to STP standards. If the task is first trained to standard in the unit, the word "UNIT" will be in this column. If the task is first trained to standard in the training base, it will identify the resident course where the task was taught.

Figure 2-1 contains a list of training locations and their brevity codes.

AIT	-	Advanced Individual Training
ANC	-	Advanced Noncommissioned Officer's Course
BCT	-	Basic Combat Training
BNC	-	Basic Noncommissioned Officer's Course
OSUT	-	One Station Unit Training
PLDC	-	Primary Leadership Development Course
SMC	-	Sergeants Major Course
UNIT	-	Trained in the Unit

**Figure 2-1. Training locations**

- Sustainment training frequency column--indicates the recommended frequency at which tasks should be trained to ensure the soldier maintains task proficiency. Figure 2-2 identifies the frequency codes to use in this column.

AN	-	annually
BM	-	bimonthly (once every two months)
MO	-	monthly
QT	-	quarterly
SA	-	semiannually

**Figure 2-2. Sustainment training frequency codes**

- Sustainment training SL column--lists the SLs of the MOS for which soldiers must receive sustainment training to ensure they maintain proficiency to SM standards.
- A chart at the end of the MTP indicates the ARTEPs which the individual critical tasks support. This establishes the crosswalk between individual and collective training.

**MOS TRAINING PLAN**

**MOS 91X**

**PART I. SUBJECT AREAS AND DUTY POSITIONS**

**SECTION 1. SUBJECT AREA CODES**

- |                                |                              |
|--------------------------------|------------------------------|
| 1. Contamination Control       | 8. Combat Psychiatry         |
| 2. Vital Signs                 | 9. Testing                   |
| 3. Emergency Medical Treatment | 10. Inpatient Interventions  |
| 4. General Medical             | 11. Patient Processing       |
| 5. Interviewing                | 12. Inpatient Supervision    |
| 6. Client Assessment           | 13. Nursing Process          |
| 7. Helping the Client          | 14. Psychiatric Patient Care |

**PART I. SUBJECT AREAS AND DUTY POSITIONS**

**SECTION 2. DUTY POSITION TRAINING REQUIREMENTS**

	<b>DUTY POSITION</b>	<b>SUBJECT AREAS</b>	<b>CROSS TRAIN</b>	<b>TRAIN-UP/MERGER</b>
SL 1/2	Mental Health Specialist	1-14	NA	NA
SL 3	Mental Health NCO	5-14	NA	NA
SL 4	Mental Health NCO	5-14	NA	91B5 Operations Sergeant 91B5M Medical 1st Sergeant

## Part II CRITICAL TASKS

## MOS 91X

## Skill Level 1

Subject Area	Task Number	Title	Training Location	Sust Tng Freq	Sust Tng SL
1. Contamination Control	081-831-0007	Perform a Patient Care Handwash	AIT	SA	1-2
	081-831-0008	Put On Sterile Gloves	AIT	SA	1-2
	081-831-0037	Disinfect Water for Drinking	AIT	AN	1-2
2. Vital Signs	081-831-0013	Measure a Patient's Temperature	AIT	AN	1-2
	081-831-0011	Measure a Patient's Pulse	AIT	AN	1-2
	081-831-0010	Measure a Patient's Respirations	AIT	AN	1-2
	081-831-0012	Measure a Patient's Blood Pressure	AIT	AN	1-2
3. Emergency Medical Treatment	081-831-0047	Evaluate a Patient	AIT	AN	1-2
	081-831-0018	Open the Airway	AIT	AN	1-2
	081-831-0019	Clear an Upper Airway Obstruction	AIT	SA	1-2
	081-831-0048	Perform Rescue Breathing	AIT	SA	1-2
	081-831-0046	Administer External Chest Compressions	AIT	SA	1-2
	081-831-0043	Immobilize a Suspected Dislocated and/or Fractured Ankle Using a Wire Ladder Splint	AIT	AN	1-2
	081-831-0044	Apply a Pneumatic Splint to a Casualty with a Suspected Fracture of an Extremity	AIT	AN	1-2
4. General Medical	081-831-0033	Initiate a Field Medical Card	AIT	AN	1-2
	081-831-0035	Manage a Convulsive and/or Seizing Patient	AIT	AN	1-2
	081-831-0038	Treat a Casualty for a Heat Injury	AIT	AN	1-2
	081-831-0039	Treat a Casualty for a Cold Injury	AIT	AN	1-2
5. Interviewing	081-832-0062	Collect Collateral Information from Records	AIT	AN	1-4
	081-832-0063	Conduct an Information Gathering Interview	AIT	AN	1-4
	081-832-0011	Conduct a Collateral Interview	AIT	AN	1-4
	081-832-0013	Present a Case for Supervision	AIT	AN	1-4
6. Client Assessment	081-832-0005	Assess a Client's Mental Status	AIT	SA	1-4
	081-832-0006	Assess a Client's Social Functioning	AIT	AN	1-4
	081-832-0064	Assess Client Psychopathology	AIT	SA	1-4
	081-832-0023	Determine a Client's Homicidal Potential	AIT	SA	1-4
	081-832-0026	Determine a Client's Suicidal Potential	AIT	SA	1-4
	081-832-0065	Assess Substance Use, Abuse, or Dependency	AIT	SA	1-4
7. Helping the Client	081-832-0007	Conduct Referral Service for Individuals	AIT	AN	1-4
	081-832-0066	Conduct a Counseling Session	AIT	SA	1-4
	081-832-0041	Initiate Follow-Up Action	AIT	SA	1-4
	081-833-0076	Apply Restraining Devices to Patients	AIT	SA	1-4

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**Part II CRITICAL TASKS**

**MOS 91X**

**Skill Level 1**

<b>Subject Area</b>	<b>Task Number</b>	<b>Title</b>	<b>Training Location</b>	<b>Sust Tng Freq</b>	<b>Sust Tng SL</b>
8. Combat Psychiatry	081-833-0103	Provide Care for a Soldier with Symptoms of Battle Fatigue	UNIT	SA	1-4
	081-833-0088	Prepare an Injection for Administration	UNIT	AN	1-4
	081-833-0089	Administer an Injection (Intramuscular, Subcutaneous, Intradermal)	UNIT	AN	1-4
9. Testing	081-832-0069	Administer the Minnesota Multiphasic Personality Inventory-2 (MMPI-2)	AIT	SA	1-4
	081-832-0070	Administer the Wechsler Adult Intelligence Scale-Revised (WAIS-R)	AIT	SA	1-4
10. Inpatient Interventions	081-832-1011	Respond to an Agitated Patient	AIT	SA	1-4
	081-832-1012	Assist in Manual Restraint Procedures	AIT	SA	1-4
	081-832-1013	Assist in Mechanical Restraint Procedures	AIT	SA	1-4
	081-832-1014	Involve Patients in Therapeutic Recreational Activities	AIT	SA	1-4
	081-832-1023	Develop a Therapeutic Relationship with a Patient	AIT	SA	1-4
	081-832-1024	Care for a Patient Receiving Electroconvulsive Therapy	AIT	SA	1-4
	081-832-1025	Place a Patient in Seclusion	AIT	SA	1-4
	081-832-1026	Monitor a Patient's Response to Psychotropic Medications	AIT	SA	1-4
11. Patient Processing	081-832-1001	Ensure a Patient's Funds and Valuables Are Secured	AIT	SA	1-4
	081-832-1002	Ensure a Patient's Personal Effects Are Secured	AIT	SA	1-4
	081-832-1003	Perform Admission Procedures on a Psychiatric Ward	AIT	SA	1-4
	081-832-1004	Prepare a Class 1a or 1b Patient for Aeromedical Evacuation	AIT	SA	1-4
	081-832-1005	Prepare a Class 1c Patient for Aeromedical Evacuation	AIT	SA	1-4
	081-832-1027	Perform Discharge Procedures on a Psychiatric Ward	AIT	SA	1-4
12. Inpatient Supervision	081-832-1006	Monitor a Patient's Use of a Potentially Dangerous Item	AIT	AN	1-4
	081-832-1007	Perform Line of Sight Observation of a Psychiatric Patient	AIT	SA	1-4
	081-832-1008	Perform 1:1 Observation of a Psychiatric Patient	AIT	SA	1-4
	081-832-1009	Account for the Location of Psychiatric Patients	AIT	AN	1-4
	081-832-1010	Escort a Psychiatric Patient	AIT	AN	1-4
13. Nursing Process	081-832-1028	Conduct an Admission Interview with a Psychiatric Patient	AIT	SA	1-4
	081-832-1029	Assist in Assessment of a Psychiatric Patient	AIT	SA	1-4
	081-832-1030	Assist in the Identification of Treatment Goals and Interventions	AIT	SA	1-4

Part II CRITICAL TASKS

MOS 91X

Skill Level 1

Subject Area	Task Number	Title	Training Location	Sust Tng Freq	Sust Tng SL
	081-832-1031	Assess a Psychiatric Patient's Suicidal Potential	AIT	SA	1-4
14. Psychiatric Patient Care	081-832-1020	Determine Patient Care Assignments	AIT	SA	1-4
	081-832-1021	Cofacilitate a Group Therapy Session	AIT	SA	1-4

**INDIVIDUAL TASK/ARTEP CROSSWALK**

	<b>057-30</b>	<b>437-30</b>	<b>456</b>	<b>467-30</b>	<b>705</b>	<b>715</b>	<b>725</b>
081-831-0007							
081-831-0008							
081-831-0037							
081-831-0013							
081-831-0011							
081-831-0010							
081-831-0012							
081-831-0047							
081-831-0018							
081-831-0019							
081-831-0048							
081-831-0046							
081-831-0043							
081-831-0044							
081-831-0033							
081-831-0035							
081-831-0038							
081-831-0039							
081-832-0062			X	X	X	X	X
081-832-0063			X	X	X	X	X
081-832-0011	X	X	X	X			
081-832-0013							
081-832-0005	X	X	X	X	X	X	

	057-30	437-30	456	467-30	705	715	725
081-832-0006	X	X		X	X	X	
081-832-0023	X	X	X	X	X	X	
081-832-0026	X	X	X	X	X	X	
081-832-0065	X	X	X	X	X	X	X
081-832-0007				X	X	X	
081-832-0066			X	X	X	X	X
081-832-0041					X	X	
081-833-0076				X	X	X	
081-833-0103				X	X	X	X
081-833-0088			X		X	X	X
081-833-0089			X		X	X	X
081-832-0069							
081-832-0070							
081-832-1011				X	X	X	X
081-832-1012				X	X	X	X
081-832-1013				X	X	X	X
081-832-1014				X	X	X	X
081-832-1023				X			
081-832-1024				X			
081-832-1025				X			
081-832-1026				X			
081-832-1001					X	X	X
081-832-1002					X	X	X
081-832-1003					X	X	X
081-832-1004				X	X	X	X

**STP 8-91X14-SM-TG**

	<b>057-30</b>	<b>437-30</b>	<b>456</b>	<b>467-30</b>	<b>705</b>	<b>715</b>	<b>725</b>
081-832-1005				X	X	X	X
081-832-1027				X			
081-832-1006				X	X	X	X
081-832-1007				X	X	X	X
081-832-1008				X	X	X	X
081-832-1009				X	X	X	X
081-832-1010				X	X	X	X
081-832-1028				X	X	X	
081-832-1029				X	X	X	
081-832-1030				X	X	X	
081-832-1031				X	X	X	
081-832-1020				X	X	X	
081-832-1021				X	X	X	

**CHAPTER 3**

**MOS / SKILL LEVEL TASKS**

**081-831-0007**

**PERFORM A PATIENT CARE HANDWASH**

**CONDITIONS**

You are about to administer patient care or have just had hand contact with a patient or contaminated material. Necessary materials and equipment: running water or two empty basins, a canteen, a water source, soap, towels (cloth or paper), and a towel receptacle or trash can.

**STANDARDS**

Perform a patient care handwash without recontaminating your hands.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Remove wristwatch and jewelry, if applicable.

*NOTE:* Rings should not be worn. If rings are worn, they should be of simple design with few crevices for harboring bacteria. Fingernails should be clean, short, and free of nail polish.

2. Roll shirt sleeves to above the elbows, if applicable.
3. Prepare to perform the handwash.
  - a. If using running water, turn on the warm water.
  - b. If running water is not available, set up the basins and open the canteen.
4. Wet your hands, wrists, and forearms.
  - a. If using running water, hold your hands, wrists, and forearms under the running water.
  - b. If running water is not available, fill one basin with enough water to cover your hands and refill the canteen.
5. Cover your hands, wrists, and forearms with soap.

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*NOTE:* For routine patient care, use regular hand soap. For an invasive procedure such as a catheterization or an injection, use antimicrobial soap.

6. Wash your hands, wrists, and forearms.
  - a. Use a circular scrubbing motion, going from the fingertips toward the elbows.
  - b. Give particular attention to creases and folds in the skin.
  - c. Wash ring(s) if present.
7. Rinse your hands, wrists, and forearms.
  - a. If using running water.
    - (1) Hold your hands higher than the elbows under the running water until all soap is removed.
    - (2) Do not touch any part of the sink or faucet.
  - b. If not using running water.
    - (1) Use a clean towel to grasp the canteen with one hand.
    - (2) Rinse the other hand, wrist, and forearm, letting the water run into the empty basin. Hold your hands higher than the elbows.
    - (3) Repeat the procedure for the other arm.
    - (4) Do not touch any dirty surfaces while rinsing your hands.
8. Dry your hands, wrists, and forearms.
  - a. Use a towel to dry one arm from the fingertips to the elbow without retracing the path with the towel.
  - b. Dispose of the towel properly without dropping your hand below waist level.
  - c. Repeat the process for the other arm using another towel.
9. Use a towel to turn off the running water, if applicable.
10. Reinspect your fingernails and clean them and rewash your hands, if necessary.

*Evaluation Preparation*

*Setup:* None

*Brief soldier:* Tell the soldier to perform a patient care handwash. You may specify which method to use. The soldier need not perform both.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Remove wristwatch and jewelry, if applicable.	P	F
2. Roll shirt sleeves to above the elbows, if applicable.	P	F
3. Prepare to perform the handwash.	P	F
4. Wet your hands, wrists, and forearms.	P	F
5. Cover your hands, wrists, and forearms with soap.	P	F
6. Wash your hands, wrists, and forearms.	P	F
7. Rinse your hands, wrists, and forearms.	P	F
8. Dry your hands, wrists, and forearms.	P	F
9. Use a towel to turn off the running water, if applicable.	P	F
10. Reinspect your fingernails and clean them and rewash your hands, if necessary.	P	F

**REFERENCES:***Required*

None

*Related*

FM 8-230

**081-831-0008**

**PUT ON STERILE GLOVES**

**CONDITIONS**

Necessary materials and equipment: handwashing facilities, sterile gloves, and a flat, clean, dry surface.

**STANDARDS**

Put on and remove sterile gloves without contaminating yourself or the gloves.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Select and inspect the package.
  - a. Select the proper size of glove.
  - b. Inspect the package for possible contamination.
    - (1) Water spots.
    - (2) Moisture.
    - (3) Tears.
    - (4) Any other evidence that the package is not sterile.
2. Perform a patient care handwash.
3. Open the sterile package.
  - a. Place the package on a flat, clean, dry surface in the area where the gloves are to be worn.
  - b. Peel the outer wrapper open to completely expose the inner package.
4. Position the inner package.
  - a. Remove the inner package touching only the folded side of the wrapper.
  - b. Position the package so that the cuff end is nearest you.

5. Unfold the inner package.
  - a. Grasp the lower corner of the package.
  - b. Open the package to a fully flat position without touching the gloves.
6. Expose both gloves.
  - a. Grasp the lower corners or designated areas on the folder.
  - b. Pull gently to the side without touching the gloves.
7. Put on the first glove.
  - a. Grasp the cuff at the folded edge and remove it from the wrapper.
  - b. Step away from the table or tray.
  - c. Keeping your hands above the waist, insert the fingers of the other hand into the glove.
  - d. Pull the glove on touching only the exposed inner surface of the glove.

*NOTE:* If there is difficulty in getting your fingers fully fitted into the glove fingers, make the adjustment after both gloves are on.

8. Put on the second glove.
  - a. Insert the fingertips of the gloved hand under the edge of the folded over cuff.

*NOTE:* You may keep the gloved thumb up and away from the cuff area or may insert it under the edge of the folded over cuff with the fingertips.

- b. Keeping your hands above the waist, insert the fingers of the ungloved hand into the glove.
  - c. Pull the glove on.
  - d. Do not contaminate either glove.
9. Adjust the gloves to fit properly.
  - a. Grasp and pick up the glove surfaces on the individual fingers to adjust them.
  - b. Pick up the palm surfaces and work your fingers and hands into the gloves.
  - c. Interlock the gloved fingers and work the gloved hands until the gloves are firmly on the fingers.

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*NOTE:* If either glove tears while putting them on or adjusting the gloves, remove both gloves and repeat the procedure.

- 10. Remove the gloves.
  - a. Grasp one glove at the heel of the hand with the other gloved hand.
  - b. Peel off the glove, retaining it in the palm of the gloved hand.
  - c. Reach under the cuff of the remaining glove with one or two fingers of the ungloved hand.
  - d. Peel off the glove over the glove being held in the palm.
  - e. Do not contaminate yourself.

**CAUTION**

Do not "snap" the gloves while removing them.

- 11. Discard the gloves IAW local SOP.
- 12. Perform a patient care handwash.

***Evaluation Preparation***

*Setup:* If performance of this task must be simulated for training and evaluation, the same gloves may be used repeatedly as long as they are properly rewrapped after each use. You may give the soldier a torn or moist glove package to test step 1.

*NOTE:* If the soldier does not know his or her glove size, have several different sizes available to try on to determine the correct size.

*Brief soldier:* Tell the soldier to put on and remove the sterile gloves.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>
1. Select and inspect the package.	P    F
2. Perform a patient care handwash.	P    F
3. Open the sterile package.	P    F

<b>Performance Measures</b>	<b>Results</b>	
4. Position the inner package.	P	F
5. Unfold the inner package.	P	F
6. Expose both gloves.	P	F
7. Put on the first glove.	P	F
8. Put on the second glove.	P	F
9. Adjust the gloves to fit properly.	P	F
10. Remove the gloves.	P	F
11. Discard the gloves IAW local SOP.	P	F
12. Perform a patient care handwash.	P	F

**REFERENCES:** None

**081-831-0037**

**DISINFECT WATER FOR DRINKING**

**CONDITIONS**

You are a member of a field sanitation team. You have just filled a Lyster bag or Water Buffalo from a source that is not safe for drinking. Necessary materials and equipment: calcium hypochlorite, clean stirring implement, mess kit spoon, a canteen cup, and a field chlorination kit.

**STANDARDS**

Disinfect water to a chlorine residual of 5 parts per million (ppm) or as ordered by the command surgeon.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Mix the stock disinfecting solution.
  - a. Add the prescribed dosage of calcium hypochlorite to 1/2 canteen cup of water.
    - (1) 3 ampules per 36 gallons of water.
    - (2) 22 ampules or 3 plastic MRE spoonfuls (from a bulk container) in 400 gallons of water.
  - b. Stir the stock solution.
2. Add the stock solution to the water container.
  - a. Pour the stock solution into the water container.
  - b. Mix the solution vigorously with a clean implement.
  - c. Cover the container.
3. Flush the faucets.
4. Test the chlorine residual after 10 minutes.
  - a. Follow the manufacturer's instructions on the color comparator in the chlorination kit to test the chlorine residual.
  - b. Retest the chlorine residual after 20 minutes.

5. Retest the water two or three times daily.

*Evaluation Preparation*

*Setup:* Test this task only when there is a need to disinfect water for drinking. Do not simulate this task for training or evaluation.

*Brief soldier:* Tell the soldier to disinfect the water. After the soldier completes step 5, ask him or her how often the water should be retested.

*Evaluation Guide*

**Performance Measures**

**Results**

1. Mix the stock disinfecting solution.	P	F
2. Add the stock solution to the water container.	P	F
3. Flush the faucets.	P	F
4. Test the chlorine residual after 10 minutes.	P	F
5. Retest the chlorine residual after 20 minutes.	P	F
6. Retest the water two or three times daily.	P	F

**REFERENCES:** None

081-831-0013

## MEASURE A PATIENT'S TEMPERATURE

### CONDITIONS

You have performed a patient care handwash. Necessary materials and equipment: disinfected oral and rectal thermometers, thermometer canisters marked "used," water soluble lubricant, gauze pads, a watch, and appropriate forms.

### STANDARDS

Record a patient's temperature to the nearest 0.2 degrees F.

### TRAINING AND EVALUATION

#### *Training Information Outline*

1. Determine which site to use.
  - a. Take an oral temperature if the patient is conscious, can follow directions, and can breathe normally through the nose.

#### **CAUTION**

Do not take an oral temperature when the patient--

- Has had recent facial or oral surgery.
- Is confused, disturbed, or heavily sedated.
- Is being administered oxygen by mouth or nose.
- Is likely to bite down on the thermometer.
- Has smoked, chewed gum, or ingested anything hot or cold within the last 15 to 30 minutes.

- b. Take a rectal temperature if the oral site is ruled out by the patient's condition or when the patient is unconscious.

#### **CAUTION**

Do not take a rectal temperature on a patient with a cardiac condition, diarrhea, a rectal disorder such as hemorrhoids, or recent rectal surgery.

- c. Take an axillary temperature if the patient's condition rules out using the other two methods.

2. Select the proper thermometer.
  - a. An oral thermometer has a blue tip and may be labeled "Oral."
  - b. A rectal thermometer has a red tip and may be labeled "Rectal."
  - c. Axillary temperatures are taken with oral thermometers.
3. Explain the procedure and position the patient.
  - a. Take an oral temperature with the patient seated or lying face up.
  - b. Take a rectal temperature with the patient lying on either side with the top knee flexed.
  - c. Take an axillary temperature with the patient lying face up with the armpit exposed.
4. Measure the temperature.
  - a. Shake the thermometer down to below 94 degrees F.
  - b. Place the thermometer at the proper site.
    - (1) If you are taking an oral temperature, place the thermometer in the heat pocket under the tongue and tell the patient to close his or her lips and not to bite down.
    - (2) If you are taking a rectal temperature, insert the thermometer 1 to 2 inches into his or her rectum.

**CAUTION**

Lubricate the tip prior to insertion. Hold the thermometer in place.

- (3) If you are taking an axillary temperature, pat the armpit dry and then place the bulb end in the center with the glass tip protruding to the front of the patient's body. Place the arm across his or her chest.
  - c. Leave the thermometer in place for the required time.
    - (1) Oral--at least 3 minutes.
    - (2) Rectal--at least 2 minutes.
    - (3) Axillary--at least 10 minutes.
5. Remove the thermometer and wipe it down with a gauze square.

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6. Read the scale.
7. Put the thermometer in the proper "used" canister.
8. Record the temperature to the nearest 0.2 degrees F on the appropriate forms and report any abnormal temperature change immediately to the supervisor.

*NOTES:* 1. The normal temperature range is-- Oral - 97.0 to 99.0 degrees F.  
Rectal - 98.0 to 100.0 degrees F.  
Axillary - 96.0 to 98.0 degrees F.

2. Record an axillary temperature with an "A" on the patient's record. Record a rectal temperature with an "R" on the patient's record.

### *Evaluation Preparation*

*Setup:* To test step 1 for evaluation purposes, create a scenario in which the patient's condition will dictate which site the soldier must choose.

*Brief soldier:* Tell the soldier to measure, evaluate, and record a patient's temperature.

### *Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Determine which site to use.	P	F
2. Select the proper thermometer.	P	F
3. Explain the procedure and position the patient.	P	F
4. Measure the temperature.	P	F
5. Remove the thermometer and wipe it down with a gauze square.	P	F
6. Read the scale.	P	F
7. Put the thermometer in the proper "used" canister.	P	F
8. Record the temperature to the nearest 0.2 degrees F on the appropriate forms and report any abnormal temperature change immediately to the supervisor.	P	F

**REFERENCES:**

*Required*

None

*Related*

FM 8-230

**081-831-0011**

**MEASURE A PATIENT'S PULSE**

**CONDITIONS**

Necessary materials and equipment: a watch, stethoscope, and appropriate forms.

**STANDARDS**

Count a patient's pulse for one full minute. Identify any abnormalities in the pulse rate, rhythm, and strength.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Position the patient so that the pulse site is accessible.
2. Palpate the pulse site.
  - a. Place the tips of the index and middle fingers on the pulse site.

*NOTE:* A stethoscope must be used to monitor the apical site.

- b. Press the fingers, using moderate pressure, to feel the pulse.
3. Count for one full minute and evaluate the pulse.

*NOTE:* To detect irregularities, it is necessary to count for one full minute.

- a. Pulse rate.
  - (1) Normal adult rate--60 to 80 beats per minute.
  - (2) Bradycardia--less than 50 beats per minute.
  - (3) Tachycardia--more than 100 beats per minute.
- b. Pulse rhythm.
  - (1) Regular.
    - (a) Usually easy to find.

- (b) Has a regular rate and rhythm.
  - (c) Varies with the individual.
- (2) Irregular/intermittent--any change from a regular beating pattern.

*NOTE:* If a peripheral pulse is irregular or intermittent, a second pulse should be taken at the carotid, femoral, or apical site. (See Figure 3-1.)

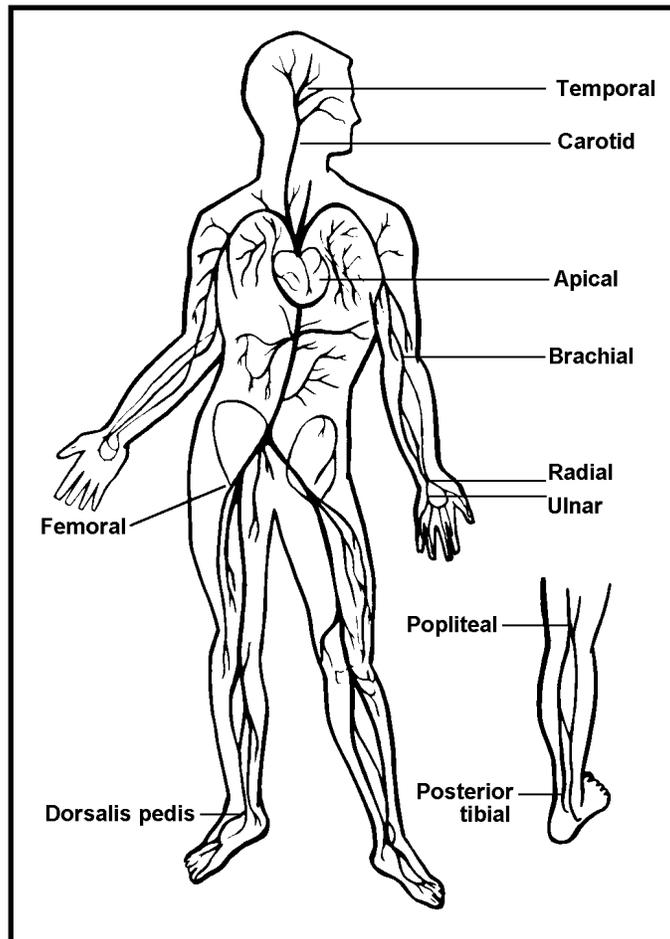


Figure 3-1

- c. Pulse strength.
- (1) Strong.
    - (a) Easy to find.

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- (b) Has even beats with good force.
  - (2) Bounding.
    - (a) Easy to find.
    - (b) Exceptionally strong heartbeats which make the arteries difficult to compress.
  - (3) Weak/thready--difficult to find.
4. Record the rate, rhythm, strength, and any significant deviations from normal on the appropriate forms.
  5. Report any significant pulse abnormalities to the supervisor immediately.

***Evaluation Preparation***

*Setup:* While the soldier is palpating a pulse site, you must palpate the corresponding site. Specify which site the soldier is to palpate. If the apical site is chosen, either a double stethoscope or separate stethoscopes may be used. A tolerance of plus or minus two beats will be allowed.

*Brief soldier:* Tell the soldier to count, evaluate, and record the patient's pulse.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Position the patient so that the pulse site is accessible.	P	F
2. Palpate the pulse site.	P	F
3. Count for one full minute and evaluate the pulse.	P	F
4. Record the rate, rhythm, strength, and any significant deviations from normal on the appropriate forms.	P	F
5. Report any significant pulse abnormalities to the supervisor immediately.	P	F

**REFERENCES:** None

**081-831-0010**

**MEASURE A PATIENT'S RESPIRATIONS**

**CONDITIONS**

Necessary materials and equipment: a watch and appropriate forms.

**STANDARDS**

Count a patient's respirations for one full minute. Identify any abnormalities in respiration rate, depth, rhythm, pattern, and quality.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Count the number of times the chest rises in one minute.

*NOTE:* The patient should not be aware that respirations are being counted. If the patient is aware, he or she often becomes tense, and an accurate count becomes extremely difficult. The normal respiration rate for an adult is generally considered to be between 12 and 20 respirations per minute.

2. Evaluate the respirations.
  - a. Depth.
    - (1) Normal--deep, even movement of the chest.
    - (2) Shallow--minimal rise and fall of the chest and abdomen.
    - (3) Deep--the rib cage expands fully, and the diaphragm descends to create a maximum capacity.
  - b. Rhythm and pattern.
    - (1) Healthy--exhalations are twice as long as inhalations.
    - (2) Irregular.
    - (3) Hypoventilation--slow and shallow respirations.
    - (4) Hyperventilation--sustained increased rate and depth of respiration.
    - (5) Sigh--deep inhalation followed by a slow audible exhalation.
    - (6) Apnea--temporary absence of breathing.

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- (7) Tachypnea--increased respiration rate, usually 24 or more breaths per minute.
- c. Quality.
  - (1) Normal--effortless, automatic, regular rate, even depth, noiseless, and free of discomfort.
  - (2) Dyspnea--difficult or labored breathing.
  - (3) Wheezing or whistling sound.
  - (4) Rattling or bubbling.
- 3. Check for the physical characteristics of abnormal respirations.
  - a. Appearance--the casualty may appear restless, anxious, pale, ashen, or cyanotic.
  - b. Position--the casualty may alter his or her position by leaning forward or may be unable to lie flat.
  - c. Cough.
    - (1) Acute--comes on suddenly.
    - (2) Chronic--has existed for a long time.
    - (3) Dry--coughs without sputum.
    - (4) Productive--coughs which expel sputum.
      - (a) Normal sputum--clear, semiliquid mucus which may appear watery, frothy, or thick.
      - (b) Abnormal sputum--may be green, yellow, gray, or blood-tinged, and may have a foul or sweetish smell.
- 4. Record the rate of respirations and any observations noted on the appropriate forms.
- 5. Report any abnormal respirations to the supervisor immediately.

***Evaluation Preparation***

*Setup:* You must count the rate with the soldier. If you are using a simulated patient, you may test step 2 by having him or her purposely exhibit abnormal breathing characteristics. A tolerance of plus or minus two counts will be allowed.

*Brief soldier:* Tell the soldier to count, evaluate, and record a patient's respirations.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>
1. Count the number of times the chest rises in one minute.	P F
2. Evaluate the respirations.	P F
3. Check for the physical characteristics of abnormal respirations.	P F
4. Record the rate of respirations and any observations noted on the appropriate forms.	P F
5. Report any abnormal respirations to the supervisor immediately.	P F

**REFERENCES:** None

**081-831-0012**

**MEASURE A PATIENT'S BLOOD PRESSURE**

**CONDITIONS**

Necessary materials and equipment: sphygmomanometer, clean stethoscope, and appropriate forms.

**STANDARDS**

Measure a patient's blood pressure and record the measurement on the appropriate forms.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Explain the procedure to the patient, if necessary.
  - a. The length of time the procedure will take.
  - b. The site to be used.
  - c. The physical sensations the patient will feel.
2. Check the equipment.
  - a. Ensure that the cuff is deflated completely and fully retighten the thumbscrew.
  - b. Ensure the sphygmomanometer gauge reads zero.

*NOTE:* Steps 2, 3, and 4 describe the procedure for taking the blood pressure at the brachial site. If the brachial site cannot be used, measure the blood pressure using a larger cuff applied to the thigh. The patient should be lying down (preferably on the stomach; otherwise, on the back with one knee flexed). Apply the cuff at mid-thigh, and place the stethoscope over the popliteal artery. The remainder of the procedure is the same as for the brachial artery site.

3. Position the patient.
  - a. Place the patient in a relaxed and comfortable sitting, standing, or lying position.

*NOTE:* A reading obtained from a standing position will be slightly higher.

- b. Place the patient's arm palm up at approximately heart level. Support the arm so that it is relaxed.

4. Place the cuff at the brachial artery site.
  - a. Place the cuff so the lower edge is 1 to 2 inches above the elbow and the bladder portion is over the artery.
  - b. Wrap the cuff just tightly enough to prevent slippage.
  - c. If applicable, clip the gauge to the cuff in alignment with the palm.
5. Position the stethoscope, if used.
  - a. Palpate for the brachial pulse.
  - b. Place the diaphragm of the stethoscope over the pulse site.
6. Inflate the cuff until the gauge reads at least 140 mm Hg or 10 mm Hg higher than the usual range for that patient, if known.

*NOTE:* If a pulsation is heard when the gauge reaches 140 mm Hg, continue to inflate the cuff 10 mm Hg beyond the point at which the last pulsation was heard.

**CAUTION**

The cuff should not remain inflated for more than 2 minutes.

7. Determine the blood pressure.
  - a. If a stethoscope is used, complete the following steps:
    - (1) Rotate the thumbscrew slowly in a counterclockwise motion, allowing the cuff to deflate slowly.
    - (2) Watch the gauge and remember the reading when the first distinct sound is heard (systolic pressure).
    - (3) Continue to watch the gauge and remember the reading where the sound changes again and becomes muffled or unclear (diastolic pressure).
    - (4) Release the remaining air.
  - b. If a stethoscope is not used, complete the following steps:
    - (1) Palpate for the radial pulse.

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(2) Rotate the thumbscrew slowly in a counterclockwise motion, allowing the cuff to deflate slowly.

(3) Watch the gauge and remember the point at which the pulse returns (systolic pressure).

*NOTES:* 1. The diastolic pressure cannot be determined using this method.

2. If the procedure must be repeated, wait at least 1 minute before repeating steps 5 through 7.

8. Record the blood pressure on the appropriate forms.

a. Record the systolic reading over the diastolic reading, for example 120/80.

b. Record the readings in even numbers.

9. Evaluate the blood pressure reading by comparing it with one of the following:

a. The patient's previous reading.

b. An average of the patient's previous readings.

c. The normal range: 100-140/60-90 for males and 90-130/50-60 for females.

10. Report abnormal readings to the supervisor.

### *Evaluation Preparation*

*Setup:* A double stethoscope should be used if available. A tolerance of  $\pm 4$  mm Hg will be allowed. If other methods are used, such as independent measurements on different sites or at different times, the evaluator must apply discretion in applying the  $\pm 4$  mm Hg standard. You will allow the soldier to retake the blood pressure at least once if the soldier feels that it is necessary to obtain an accurate reading. You will use discretion in allowing additional repetitions based upon the difficulty of obtaining a reading on the patient.

*Brief soldier:* Tell the soldier to take a patient's blood pressure. Tell the soldier that the blood pressure may be retaken, if necessary, to obtain an accurate reading.

### *Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Explain the procedure to the patient, if necessary.	P	F
2. Check the equipment.	P	F
3. Position the patient.	P	F

<b>Performance Measures</b>	<b>Results</b>	
4. Place the cuff just tightly enough to prevent slippage.	P	F
5. Position the stethoscope, if used.	P	F
6. Inflate the cuff until the gauge reads at least 140 mm Hg or 10 mm Hg higher than the usual range for that patient, if known.	P	F
7. Determine the blood pressure.	P	F
8. Record the blood pressure on the appropriate forms.	P	F
9. Evaluate the blood pressure.	P	F
10. Report any abnormal readings to the supervisor.	P	F

**REFERENCES:** None

**081-831-0047**

**EVALUATE A PATIENT**

**CONDITIONS**

You find a soldier who has signs or symptoms of an injury.

**STANDARDS**

All the steps necessary to evaluate the patient are done in order. All apparent injuries and/or conditions of the patient are identified and treated.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Check the patient for responsiveness.
  - a. Gently shake the patient's shoulder.
  - b. Shout, "Are you O.K.?"
  - c. Watch for response.
  - d. If the patient is conscious, ask where he or she feels different than usual or where it hurts. Then go to step 3.

*NOTES:* 1. If the patient is conscious but is choking and cannot talk, stop the evaluation and begin treatment. (See task 081-831-0019.)

2. If there are any signs of nerve agent poisoning, immediately mask the patient and administer the antidote. (See STP 21-1-SMCT, task 081-831-1031.)

**CAUTION**

If you think that the patient has an injured or broken neck or back, do not move the patient unless it is necessary to save his or her life.

- e. If the patient is unconscious, continue the evaluation with step 2.

2. Check for breathing.

a. Place your ear over the patient's nose or mouth while looking toward the patient's chest and abdomen.

(1) Look for the patient's chest to rise and fall.

(2) Listen for air escaping during exhalation.

(3) Feel for the flow of air on your ear.

b. If the patient is not breathing, stop the evaluation and begin treatment. (See task 081-831-0018.)

*NOTE:* The carotid pulse will be checked, if necessary, during the performance of rescue breathing.

c. If the patient is breathing, continue the evaluation with step 3.

3. Check for bleeding.

*NOTE:* If the injury has been caused by a missile (for example, a bullet or shrapnel), check for entry and exit wounds.

a. Look for blood-soaked clothes, spurts of blood, or pooling of blood under the body.

b. If bleeding is present, stop the evaluation and begin treatment. (See tasks in STP 21-1-SMCT.)

(1) Arm or Leg Wound, 081-031-1016.

(2) Partial or Complete Amputation, 081-831-1017.

(3) Open Head Wound, 081-831-1033.

(4) Open Abdominal Wound, 081-831-1025.

(5) Open Chest Wound, 081-831-1026.

**CAUTION**

In a chemically contaminated area, do not expose the wound.

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### 4. Check for shock.

#### a. Check the patient for the following signs or symptoms:

- (1) Cool, clammy skin.
- (2) Pale skin.
- (3) Rapid pulse.
- (4) Restlessness.
- (5) Excessive blood loss.
- (6) Thirst.
- (7) Increased respiratory rate.
- (8) Confusion.
- (9) Blotchy or bluish skin, especially around the mouth.
- (10) Nausea and/or vomiting.

b. If any signs or symptoms are noted, stop the evaluation and begin treatment. (See STP 21-1-SMCT, task 081-831-1005.)

### CAUTION

You must treat leg fractures before elevating the legs as a treatment for shock.

### 5. Check for fractures.

#### a. Check the patient for visible evidence of fractures.

b. If the patient is conscious, ask if he or she suspects the presence of a fracture.

c. If a fractured extremity is suspected, stop the evaluation and begin treatment. (See tasks 081-831-0043 and 081-831-0044, and STP 21-1-SMCT, task 081-031-1034.)

*NOTE:* After applying each cravat, check the pulse distal to the fracture.

d. If a fractured neck or spine is suspected, stop the evaluation and do the following:

- (1) Tell the patient not to move.
- (2) If a back injury is suspected, gently place padding under the natural arch of the patient's back.
- (3) If a neck injury is suspected, place a roll of cloth under the patient's neck and put boots filled with dirt, sand, or rocks, on both sides of the head.

6. Check for burns.

- a. Check the patient for reddened, blistered, or charred skin, or for singed clothing.

*NOTE:* Some burns, such as chemical, may not readily be seen unless the patient's clothing is removed.

- b. If the patient is burned, stop the evaluation and begin treatment. (See STP 21-1-SMCT, task 081-831-1007.)

7. Check for head injury.

- a. Check the patient for the following signs or symptoms:

- (1) Unequal pupils.
- (2) Drainage from the ear(s), nose, mouth, or injury site.
- (3) Slurred speech.
- (4) Confusion.
- (5) Drowsiness.
- (6) Headache or dizziness.
- (7) Loss of memory.
- (8) Loss of consciousness.
- (9) Convulsions or twitching.
- (10) Staggering.
- (11) Nausea or vomiting.

- b. If a head injury is suspected, watch for symptoms which would require performance of CPR, control of bleeding, or treatment for shock. Evacuate the patient for more intensive medical treatment.

8. Check the vital signs. (See tasks 081-831-0010, 081-831-0011, and 081-831-0012.)

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### 9. Check for symptoms of substance abuse.

#### a. Alcohol abuse.

- (1) Decreased inhibitions.
- (2) Decreased sense of pain.
- (3) Double vision.
- (4) Vertigo.
- (5) Slurred speech.
- (6) Confusion.
- (7) Staggering.
- (8) Profuse perspiration.

#### b. Barbiturates--an intoxicated state similar to that of alcohol intoxication.

#### c. Stimulants.

- (1) Elevated blood pressure, pulse and respiration rate, and temperature.
- (2) Dilated pupils.
- (3) Flushed skin.
- (4) Suppressed appetite.
- (5) Exhilaration.
- (6) Periods of high energy.
- (7) Wakefulness.
- (8) Alertness.
- (9) Hyperactivity.
- (10) Hyperexcitability.

#### d. Narcotics.

- (1) Sense of calm.
  - (2) Relaxation.
  - (3) Euphoria.
  - (4) Pinpoint pupils.
- e. Psychedelics.
- (1) Loss of contact with reality.
  - (2) Delusions.
  - (3) Hallucinations.
  - (4) Illusions.
  - (5) Personality changes.
- f. Mild tranquilizers.
- (1) Relaxation.
  - (2) Drowsiness.

*NOTE:* It is possible that some, few, or all of the signs and symptoms may be seen. The presence of any or all of the symptoms indicates a possible substance abuse. Diagnosis by a physician is necessary to confirm substance abuse.

10. Record the treatment given and observations noted on the Field Medical Card. (See task 081-831-0033.)

11. Evacuate the patient, if necessary.

### ***Evaluation Preparation***

*Setup:* Prepare a "patient" for the soldier to evaluate by simulating one or more wounds or conditions. Wounds may be simulated using a moulage set, or other materials. A "conscious patient" can be coached to show signs of such conditions as shock or head injury and to respond to the soldier's questions about the location of pain or other symptoms of injury. However, the evaluator will cue the soldier during evaluation of an "unconscious patient" as to whether the patient is breathing and describe the signs or conditions, such as shock, as the soldier is making the checks.

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*Brief soldier:* Tell the soldier to evaluate the patient and identify all wounds and/or conditions. Tell the soldier to tell you what first aid action (give cardiopulmonary resuscitation (CPR), bandage the wound) he or she would take but that not to perform first aid unless a neck or back injury is found.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Check for responsiveness.	P	F
2. Check for breathing, if necessary.	P	F
3. Check for bleeding.	P	F
4. Check for shock.	P	F
5. Check for fractures.	P	F
6. Check for burns.	P	F
7. Check for head injury.	P	F
8. Check vital signs.	P	F
9. Check for substance abuse.	P	F
10. Record the treatment given and observations noted.	P	F
11. Evacuate the patient, if necessary.	P	F
12. Do all necessary steps in order.	P	F
13. Identify all wounds and/or conditions.	P	F
14. Identify appropriate first aid action for each wound and/or condition.	P	F

**REFERENCES:**

*Required*

None

*Related*

FM 21-11  
STP 21-1-SMCT

081-831-0018

## OPEN THE AIRWAY

### CONDITIONS

You are evaluating a casualty who is not breathing. You are not in an NBC environment.

### STANDARDS

Complete all of the steps required to open the casualty's airway without causing unnecessary injury.

### TRAINING AND EVALUATION

#### *Training Information Outline*

1. Roll the casualty onto his or her back if necessary.
  - a. Kneel beside the casualty.
  - b. Raise the near arm and straighten it out above the head.
  - c. Adjust the legs so that they are together and straight or nearly straight.
  - d. Place one hand on the back of the casualty's head and neck.
  - e. Grasp the casualty under the arm with the free hand.
  - f. Pull steadily and evenly toward yourself, keeping the head and neck in line with the torso.
  - g. Roll the casualty as a single unit.
  - h. Place the casualty's arms at his or her sides.
2. Establish the airway using the head-tilt/chin-lift or jaw thrust method.
  - a. Head-tilt/chin-lift method.

#### **CAUTION**

Do not use this method if a spinal or neck injury is suspected.

*NOTE:* Remove any foreign material or vomitus seen in the mouth as quickly as possible.

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- (1) Kneel at the level of the casualty's shoulders.
- (2) Place one hand on the casualty's forehead and apply firm, backward pressure with the palm of the hand to tilt the head back.
- (3) Place the fingertips of the other hand under the bony part of the casualty's lower jaw, bringing the chin forward.

### CAUTIONS

1. Do not use the thumb to lift the lower jaw.
2. Do not press deeply into the soft tissue under the chin with the fingers.
3. Do not completely close the casualty's mouth.

- b. Jaw thrust.

### CAUTION

Use this method if a spinal or neck injury is suspected.

- (1) Kneel at the top of the casualty's head.
- (2) Grasp the angles of the casualty's lower jaw.
- (3) Rest the elbows on the surface on which the casualty is lying.
- (4) Lift with both hands displacing the lower jaw forward while tilting the head backward.

*NOTE:* If this procedure is unsuccessful, tilt the head very slightly.

3. Check for breathing within 3 to 5 seconds. While maintaining the open airway position, place an ear over the casualty's mouth and nose, looking toward the chest and stomach.
  - a. Look for the chest to rise and fall.
  - b. Listen for air escaping during exhalation.
  - c. Feel for the flow of air on the side of your face.
4. Take appropriate action.

a. If the casualty resumes breathing, maintain the airway and place the casualty in the recovery position.

- (1) Roll the casualty as a single unit onto his or her side.
- (2) Place the lower arm behind his or her back.
- (3) Place the hand of the upper arm under his or her chin.
- (4) Flex the upper leg.

*NOTE:* Check the casualty for other injuries, if necessary.

b. If the casualty does not resume breathing, perform rescue breathing. (See task 081-831-0048.)

### *Evaluation Preparation*

*Setup:* Place a CPR mannequin or another soldier acting as the casualty face down on the ground. For training and evaluation, you may specify to the soldier whether the casualty has a spinal injury to test step 2, or you may create a scenario in which the casualty's condition will dictate to the soldier how to treat the casualty. After step 3 tell the soldier whether the casualty is breathing or not and ask what should be done.

*Brief soldier:* Tell the soldier to open the casualty's airway.

### *Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Roll the casualty onto his or her back, if necessary.	P	F
2. Establish the airway using the head-tilt/chin-lift or jaw thrust method.	P	F
3. Check for breathing within 3 to 5 seconds.	P	F
4. Take appropriate action.	P	F
5. Do not cause further injury to the casualty.	P	F

**REFERENCES:** None

**081-831-0019**

**CLEAR AN UPPER AIRWAY OBSTRUCTION**

**CONDITIONS**

You are evaluating a casualty who is not breathing or is having difficulty breathing, and you suspect the presence of an upper airway obstruction.

**STANDARDS**

Complete, in order, all the steps necessary to clear an object from a casualty's upper airway. Continue the procedure until the casualty can talk and breathe normally or until you are relieved by a qualified person.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Clear the airway.
  - a. Conscious casualty.
    - (1) Determine whether or not the casualty needs help. Ask the casualty whether he or she is choking.
      - (a) If the casualty has good air exchange (is able to speak, coughs forcefully, or wheezes between coughs), do not interfere except to encourage the casualty.
      - (b) If the casualty has poor air exchange (weak, ineffective cough; high-pitched noise while inhaling; increased respiratory difficulty; and possible cyanosis), continue with step 1a(2).
      - (c) If the casualty has a complete airway obstruction (is unable to speak, breathe, or cough and may clutch the neck between the thumb and fingers), continue with step 1a(2).
    - (2) If the casualty is lying down, bring him or her to a sitting or standing position.
    - (3) Apply abdominal or chest thrusts.

*NOTE:* Use abdominal thrusts unless the casualty is in the advanced stages of pregnancy, is very obese, or has a significant abdominal wound.

- (a) Abdominal thrusts.
  - 1) Stand behind the casualty and wrap your arms around his or her waist.

2) Make a fist with one hand and place the thumb side of the fist against the casualty's abdomen in the midline slightly above the navel and well below the tip of the xiphoid process.

3) Grasp the fist with your other hand and press the fist into the casualty's abdomen with quick backward and upward thrusts.

4) Continue giving thrusts until the blockage is expelled or the casualty becomes unconscious.

*NOTE:* Make each thrust a separate, distinct movement given with the intent of relieving the obstruction.

(b) Chest thrusts.

1) Stand behind the casualty and encircle his or her chest with your arms just under the armpits.

2) Make a fist with one hand and place the thumb side of the fist against the middle of the casualty's breastbone.

3) Grasp the fist with your other hand and give backward thrusts.

4) Continue giving thrusts until the blockage is expelled or the casualty becomes unconscious.

**CAUTION**

Do not position the hand on the xiphoid process or the lower margins on the rib cage.

*NOTES:* 1. Administer each thrust with the intent of relieving the obstruction.

2. If the casualty becomes unconscious, position the casualty on his or her back, perform a finger sweep (see step 1b(2)), open the airway (see task 081-831-0018), and then start rescue breathing procedures (see task 081-831-0048).

b. Unconscious casualty.

*NOTE:* Perform abdominal or chest thrusts on the unconscious casualty only after attempts to open the airway and ventilate the casualty indicate that the airway is obstructed.

(1) Apply abdominal or chest thrusts.

*NOTE:* Use abdominal thrusts unless the casualty is in the advanced stages of pregnancy, is very obese, or has a significant abdominal wound.

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(a) Abdominal thrusts.

- 1) Kneel astride the casualty's thighs.
- 2) Place the heel of one hand against the casualty's abdomen in the midline slightly above the navel and well below the tip of the xiphoid process.
- 3) Place the other hand directly on top of the first.
- 4) Press into the abdomen with quick upward thrusts up to five times.

(b) Chest thrusts.

- 1) Kneel close to either side of the casualty's body.
- 2) With the middle and index fingers of the hand nearest the casualty's legs, locate the lower margin of the casualty's rib cage on the side nearest you.
- 3) Move the fingers up the rib cage to the notch where the ribs meet the sternum in the center of the lower part of the chest.
- 4) With the middle finger on this notch, place the index finger next to it on the lower end of the sternum.
- 5) Place the heel of the other hand on the lower half of the sternum next to the index finger of the first hand.
- 6) Remove the first hand from the notch and place it on top of the hand on the sternum so that the hands are parallel to each other.

*NOTE:* You may either extend or interlace your fingers but keep the fingers off the casualty's chest.

- 7) Lock your elbows into position, straighten your arms, and position your shoulders directly over your hands.
- 8) Press straight down depressing the sternum 1.5 to 2 inches and then release the pressure completely without lifting the hands from the chest.
- 9) Repeat the chest thrust up to five times.

*NOTE:* Make each thrust a separate, distinct movement given with the intent of relieving the obstruction.

- (2) Perform a finger sweep.

- (a) Open the casualty's mouth by grasping both the tongue and lower jaw with your thumb and fingers and lifting.
- (b) Insert the index finger of your other hand down along the inside of the cheek and deeply into the throat to the base of the tongue.
- (c) Use a hooking motion to attempt to dislodge the foreign body and maneuver it into the mouth for removal.

**CAUTION**

Do not force the object deeper into the airway.

- (3) Attempt to ventilate. If the airway is still not clear, repeat the sequence of thrusts, finger sweep, and attempt to ventilate until the airway is cleared or you are relieved by qualified personnel.
2. When the object is dislodged, check for breathing. Perform rescue breathing, if necessary (see task 081-831-0048) or continue to evaluate the casualty for other injuries.

***Evaluation Preparation***

*NOTE:* Only the procedure for clearing an airway obstruction in a conscious casualty will be evaluated. The procedure for an unconscious casualty can be evaluated as a part of task 081-831-0048.

*Setup:* You will need another soldier to play the part of the casualty.

*Brief soldier:* Describe the symptoms of a casualty with good air exchange, poor air exchange, or a complete airway obstruction. Ask the soldier what should be done and score step 1 based on the answer. Then, tell the soldier to clear an upper airway obstruction. Tell the soldier to demonstrate how to position the casualty, where to stand, and how to position his or her hands for the thrusts. The soldier must tell you how they should be done and how many thrusts should be performed. Ensure that the soldier understands that he or she must not actually perform the thrusts. After completion of step 5, ask the soldier what must be done if the casualty becomes unconscious.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>
1. Determine whether the casualty needs help.	P F
2. Move the casualty to a sitting or standing position, if necessary.	P F
3. Stand behind the casualty.	P F

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<b>Performance Measures</b>	<b>Results</b>	
4. Position your arms and hands properly to perform the thrusts.	P	F
5. Tell how to perform the thrusts and how many should be performed.	P	F
6. State that the following actions would be taken if the casualty becomes unconscious:	P	F
a. Reposition the casualty.		
b. Perform a finger sweep.		
c. Open the airway.		
d. Perform rescue breathing procedures.		
7. Complete all necessary steps in order.	P	F

**REFERENCES:** None

081-831-0048

## PERFORM RESCUE BREATHING

### CONDITIONS

You are treating a casualty who is unconscious and is not breathing. You have opened the airway. You are not in an NBC environment.

### STANDARDS

Complete, in order, all the steps necessary to restore breathing. Continue the procedure until the casualty starts to breathe or until you are relieved by another qualified person, stopped by a physician, required to perform CPR, or too exhausted to continue.

### TRAINING AND EVALUATION

#### *Training Information Outline*

1. Ventilate the casualty using the mouth-to-mouth or mouth-to-nose method as appropriate.

*NOTE:* The mouth-to-nose method is recommended when you cannot open the casualty's mouth, there are jaw or mouth injuries, or you cannot maintain a tight seal around the casualty's mouth.

- a. Mouth-to-mouth method.

- (1) Maintain the chin-lift while pinching the nostrils closed using the thumb and index fingers of the hand on the casualty's forehead.

- (2) Take a deep breath and make an airtight seal around the casualty's mouth with your mouth.

- (3) Blow two full breaths (1.5 to 2 seconds each) into the casualty's mouth, taking a breath between them while watching for the chest to rise and fall and listening and feeling for air to escape during exhalation.

- (4) If the chest rises and air escapes, go to step 4.

- (5) If the chest does not rise or air does not escape, continue with step 2.

- b. Mouth-to-nose method.

- (1) Maintain the head-tilt with the hand on the forehead while using the other hand to lift the casualty's jaw and close the mouth.

- (2) Take a deep breath and make an airtight seal around the casualty's nose with your mouth.

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(3) Blow two full breaths (1.5 to 2 seconds each) into the casualty's nose, taking a breath between them while watching for the chest to rise and fall and listening and feeling for air to escape during exhalation.

*NOTE:* It may be necessary to open the casualty's mouth or separate the lips to allow air to escape.

(4) If the chest rises, go to step 4.

(5) If the chest does not rise, continue with step 2.

2. Reposition the head to ensure an open airway and repeat step 1 if necessary.

a. If the chest rises, go to step 4.

b. If the chest does not rise, continue with step 3.

3. Clear an airway obstruction, if necessary. (See task 081-831-0019.) When the obstruction has been cleared, continue with step 4.

4. Check the carotid pulse for 5 to 10 seconds.

a. While maintaining the head-tilt with one hand, place the index and middle fingers of the other hand on the casualty's throat.

b. Slide the fingers into the groove beside the casualty's Adam's apple and feel for a pulse for 5 to 10 seconds.

c. If a pulse is present, go to step 5.

d. If a pulse is not found, begin CPR. (See task 081-831-0046.)

5. Continue rescue breathing.

a. Ventilate the casualty at the rate of about 10 to 12 breaths per minute.

b. Watch for rising and falling of the chest.

c. Recheck for pulse and breathing after every 12 breaths.

*NOTE:* Although not evaluated, continue rescue breathing as stated in the task standard. When breathing is restored, watch the casualty closely, maintain an open airway, and check for other injuries. If the casualty's condition permits, place him or her in the recovery position. (See task 081-831-0018.)

### *Evaluation Preparation*

*Setup:* For training and evaluation, a CPR mannequin must be used. Position the mannequin on its back with its neck hyperextended. To test step 1, you may specify to the soldier whether to use the mouth-to-mouth or mouth-to-nose method, or you may create a scenario in which the casualty's condition dictates which method is to be used. You may determine how much of the task is tested by telling the soldier whether the airway is clear or a pulse is found as the soldier proceeds through the task. However, you should ensure that the soldier is routed through the task far enough to continue rescue breathing after checking the carotid pulse.

*Brief soldier:* Tell the soldier to perform rescue breathing.

### *Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Ventilate the casualty using the mouth-to-mouth or mouth-to-nose method, as appropriate.	P	F
2. Reposition the head to ensure an open airway and repeat step 1, if necessary.	P	F
3. Clear an airway obstruction, if necessary.	P	F
4. Check the carotid pulse for 5 to 10 seconds.	P	F
5. Continue rescue breathing.	P	F
6. Complete all necessary steps in order.	P	F

**REFERENCES:** None

**081-831-0046**

**ADMINISTER EXTERNAL CHEST COMPRESSIONS**

**CONDITIONS**

You are treating a casualty who is not breathing and has no pulse. The airway is open and is clear. Another soldier who is CPR qualified may be available to assist or may arrive while you are performing one-rescuer CPR. You are not in an NBC environment.

**STANDARDS**

Continue CPR until the pulse is restored or until the rescuer(s) is/are relieved by other qualified persons, stopped by a physician, or too tired to continue.

**TRAINING AND EVALUATION**

*Training Information Outline*

*Perform one-rescuer CPR.*

1. Ensure that the casualty is positioned on a hard, flat surface.
2. Position the hands for external chest compressions.
  - a. With the middle and index fingers of the hand nearest the casualty's feet, locate the lower margin of the casualty's rib cage on the side near the rescuer.
  - b. Move the fingers up the rib cage to the notch where the ribs meet the sternum in the center of the lower part of the chest.
  - c. With the middle finger on the notch, place the index finger next to it on the lower end of the sternum.
  - d. Place the heel of the other hand on the lower half of the sternum, next to the index finger of the first hand.
  - e. Remove the first hand from the notch and place it on top of the hand on the sternum so that both hands are parallel to each other.

*NOTE:* You may either extend or interlace your fingers but keep the fingers off the casualty's chest.

3. Position your body.
  - a. Lock your elbows with the arms straight.

- b. Position your shoulders directly over your hands.
4. Give 15 compressions.
- a. Press straight down to depress the sternum 1.5 to 2 inches.
  - b. Come straight up and completely release pressure on the sternum to allow the chest to return to its normal position. The time allowed for release should equal the time required for compression.

**CAUTION**

Do not remove the heel of your hand from the casualty's chest or reposition your hand between compressions.

- c. Give 15 compressions in 9 to 11 seconds (at a rate of 80 to 100 per minute).
5. Give two full breaths.
- a. Move quickly to the casualty's head and lean over.
  - b. Open the casualty's airway. (See task 081-831-0018.)
  - c. Give two full breaths (1.5 to 2 seconds each).
6. Repeat steps A2 through A5 four times.
7. Assess the casualty.
- a. Check for the return of the carotid pulse for 3 to 5 seconds.
    - (1) If the pulse is present, continue with step A7b.
    - (2) If the pulse is absent, continue with step A8.
  - b. Check breathing for 3 to 5 seconds.
    - (1) If breathing is present, monitor breathing and pulse closely.
    - (2) If breathing is absent, perform rescue breathing only. (See task 081-831-0048.)
8. Resume CPR with compressions.
9. Recheck for pulse every 3 to 5 minutes.

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10. Continue to alternate chest compressions and rescue breathing until--

- a. The casualty is revived.
- b. You are too tired to continue.
- c. You are relieved by competent person(s).
- d. The casualty is pronounced dead by an authorized person.
- e. A second rescuer states, "I know CPR," and joins you in performing two-rescuer CPR.

*NOTE:* A qualified second rescuer joins the first rescuer at the end of a cycle after a check for pulse by the first rescuer. The new cycle starts with one ventilation by the first rescuer, and the second rescuer becomes the compressor. Two-rescuer CPR is then initiated.

11. Perform two-rescuer CPR, if applicable.

- a. Compressor: Give five chest compressions at the rate of 80 to 100 per minute.  
Ventilator: Maintain an open airway and monitor the carotid pulse occasionally for adequacy of chest compressions.
- b. Compressor: Pause.  
Ventilator: Give one full breath (1.5 to 2 seconds).
- c. Compressor: Continue to give chest compressions until a change in positions is initiated.  
Ventilator: Continue to give ventilations until the compressor indicates that a change is to be made.
- d. Compressor: Give a clear signal to change positions.  
Ventilator: Remain in the rescue breathing position.
- e. Compressor: Give the fifth compression.  
Ventilator: Give the breath following the fifth compression.
- f. Compressor and ventilator simultaneously switch positions.
- g. New Ventilator: Check the casualty's carotid pulse for 5 seconds.  
If present state, "There is a pulse," and perform rescue breathing.  
If not present state, "No pulse." Give the casualty one breath and tell the new compressor to give chest compressions.  
New compressor: Position the hands to begin chest compressions as directed by the ventilator.
- h. Ventilator: Continue to give one breath on each fifth upstroke of chest compressions and ensure that the chest rises.

Compressor: Continue to give chest compressions at the rate of 80 to 100 per minute.

*NOTE:* If signs of gastric distension are noted, do the following:

1. Recheck and reposition the airway.
2. Watch for the rise and fall of the chest.
3. Ventilate the casualty only enough to cause the chest to rise.

#### CAUTIONS

1. Do not push on the abdomen.
2. If the casualty vomits, turn the casualty on the side, clear the airway, and then continue CPR.

12. Continue to perform CPR as stated in the task standard.

*NOTE:* The rescuer doing rescue breathing should recheck the carotid pulse every 3 to 5 minutes.

13. When the pulse and breathing are restored, continue to evaluate the casualty. If the casualty's condition permits, place him or her in the recovery position. (See task 081-831-0018.)

#### CAUTION

During evacuation, CPR or rescue breathing should be continued en route if necessary. When pulse and breathing are restored, the casualty should be watched closely.

#### *Evaluation Preparation*

*Setup:* For training and evaluation a CPR mannequin must be used. Place the mannequin face up on the floor. One-rescuer CPR, two-rescuer CPR, or a combination of both (see NOTE after step 10e) can be evaluated. If two soldiers are involved, they will be designated as "rescuer #1" and "rescuer #2." Rescuer #1 will start in the chest compression position and will be the only one scored during performance of the task. The evaluator will ensure that all aspects of the task are evaluated by indicating whether pulse is present and when the rescuers should change positions.

*Brief soldier:* If two soldiers are involved, tell them about their roles as rescuer #1 and #2. Ask rescuer #1 on what kind of surface the casualty should be positioned. Then, tell the soldier(s) to perform one-rescuer or two-rescuer CPR, as appropriate.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Position the casualty on a hard flat surface.	P	F
2. Properly position your hands during chest compressions.	P	F
3. Administer the correct number of chest compressions.	P	F
4. Give the chest compressions at the rate of 80 to 100 per minute.	P	F
5. Administer the correct number of breaths.	P	F
6. Give the breaths at the correct rate.	P	F
7. Check the carotid pulse for about 5 seconds approximately 1 minute after starting CPR.	P	F
8. Recheck the carotid pulse every 3 to 5 minutes.	P	F
9. Perform the transition to two-rescuer CPR correctly, if applicable.	P	F
10. Change position during two-rescuer CPR correctly, if applicable.	P	F
11. Continue CPR as stated in the task standard.	P	F

**REFERENCES:** None

081-831-0043

**IMMOBILIZE A SUSPECTED DISLOCATED AND/OR FRACTURED ANKLE  
USING A WIRE LADDER SPLINT**

**CONDITIONS**

You are evaluating a casualty who has a suspected dislocated or fractured ankle. Necessary materials and equipment: two wire ladder splints, three cravats, padding materials, and scissors or a knife.

**STANDARDS**

Immobilize an ankle without causing unnecessary injury. Do not impair circulation.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Cut the boot laces until all laces are separated.
2. Cut the boot tongue from the top to the bottom.
3. Check for a pedal pulse. (See task 081-831-0011.)

**CAUTION**

If no pulse is found, evacuate the casualty as soon as possible.

4. Prepare the splints.
  - a. Bend down both metal prongs at the top of both splints away from the smooth sides of the splints.
  - b. Bend down the first wire ladder splint into an "L" shape with the short end no longer than the length of the uninjured foot.
  - c. Bend back the long end of the "L" shaped splint at the level of the boot top until it lies flat against the rough (outer) side of the splint.
  - d. Place the other wire ladder splint on the ground, place the uninjured foot on the middle portion, and then bend both sides up to form a "U" shape.
  - e. Join the "L" and "U" splints.

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- (1) Fit the "U" splint around the "L" splint to form a cradle.
  - (2) Hold the splint together.
5. Apply the splint around the casualty's ankle.
- a. For an unconscious casualty, gently lift the leg and slide the cradle under the leg until the short end of the "L" touches the boot sole.

**CAUTION**

Do not twist the casualty's leg and ankle.

- b. For a conscious casualty--
    - (1) Tell the casualty to hold his or her leg up slightly.
    - (2) Slide the cradle under the leg until the short end of the "L" touches the boot sole.
6. Tie the first cravat around the splints.
- a. Fully unfold the cravat and center it on the outer side of the leg just above the fracture site.
  - b. Bring the tails around to the inside of the leg, cross them, and bring them back to the outer side of the leg.
  - c. Tie a nonslip knot.
7. Check the pedal pulse.

**CAUTION**

If symptoms of circulation or nerve impairment are present after tying any one of the three cravats, you must loosen the cravat.

- a. If no pulse is detected, attempt to slide two fingers between the cravat and the front of the boot.
- b. If the fingers will not fit, retie the cravat and recheck the pulse.

*NOTE:* If the cravat is not too tight and there is no pulse, continue with step 8 and evacuate the casualty as soon as possible.

- c. If a pulse is detected, continue with the next step.
8. Tie the second cravat.
    - a. Fully unroll the cravat and "cup" the center of the cravat around the splint at the boot heel.
    - b. Bring the tail around the foot, cross the cravats on the top of the boot toe, and bring the tails of the cravats down under the boot sole.
    - c. Tie a nonslip knot on the outer edge of the splint.
  9. Check the pedal pulse IAW step 7.
  10. Tie the third cravat.
    - a. Fully unroll the cravat and center it on the outer side of the leg at the top of the splints.
    - b. Bring the tails around to the inner side of the leg, cross them, and bring them back to the outer side of the leg.
    - c. Tie a nonslip knot on the outer edge of the splint.
  11. Check the pedal pulse IAW step 7.
  12. Record the treatment given. (See task 081-831-0033.)

*NOTE:* Although not evaluated, continue to evaluate the casualty.

### *Evaluation Preparation*

*Setup:* For training and evaluation, have another soldier act as the casualty. To test steps 1 and 2 have the soldier explain the procedure. Do not have him or her cut the laces or the boot. Specify which ankle is injured.

*Brief soldier:* Tell the soldier to splint the injured ankle.

### *Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Cut the boot laces until all laces are separated.	P    F
2. Cut the boot tongue from the top to the bottom.	P    F
3. Check for a pedal pulse.	P    F

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<b>Performance Measures</b>	<b>Results</b>	
4. Prepare the splints.	P	F
5. Apply the splint around the casualty's ankle.	P	F
6. Tie the first cravat around the splints.	P	F
7. Check the pedal pulse.	P	F
8. Tie the second cravat.	P	F
9. Check the pedal pulse.	P	F
10. Tie the third cravat.	P	F
11. Check the pedal pulse.	P	F
12. Record the treatment given.	P	F
13. Do not cause further injury to the casualty.	P	F

**REFERENCES:** None

081-831-0044

**APPLY A PNEUMATIC SPLINT TO A CASUALTY WITH A SUSPECTED FRACTURE  
OF AN EXTREMITY**

**CONDITIONS**

You are evaluating a casualty who has a suspected fractured extremity. Necessary equipment: pneumatic splint.

**STANDARDS**

Immobilize an extremity without causing unnecessary injury or impairing circulation.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Check the equipment both visually and manually for the following:
  - a. Holes.
  - b. Function of the air valve.
  - c. Function of the zipper.
2. Open the splint completely and place it next to the injured extremity.
3. Lift and support the injured extremity.
4. Place the splint under the injured extremity and position the splint around the injured area.
5. Inflate the splint.
  - a. Draw the zipper completely closed.
  - b. Inflate the splint by mouth until a slight indentation can be made with a thumb or finger.

**CAUTION**

Do not use an air pump.

**STP 8-91X14-SM-TG**

6. Monitor the splint.
  - a. Partially deflate the splint every 20 to 30 minutes to reestablish peripheral circulation.
  - b. In an aircraft limit the inflation pressure to that which is adequate for fracture support only.

**CAUTION**

Do not overinflate. Temperature and air pressure may cause too much pressure to be exerted, thereby cutting off circulation to the extremity.

7. Check for peripheral circulation.
  - a. Check the color and temperature of the limb distal to the splint.
  - b. Question the casualty about numbness and tingling sensations.
  - c. If the circulation is impaired, partially deflate the splint.

***Evaluation Preparation***

*Setup:* For training and evaluation have another soldier act as the casualty and specify the location of the fracture.

*Brief soldier:* Tell the soldier to apply the pneumatic splint to the specified fractured extremity. To test step 6, have the soldier tell you what he or she would do to monitor the splint under normal conditions and in an aircraft.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Check the equipment both visually and manually.	P	F
2. Open the splint completely and place it next to the injured extremity.	P	F
3. Lift and support the injured extremity.	P	F
4. Place the splint under the injured extremity and position the splint around the injured area.	P	F
5. Inflate the splint.	P	F

**Performance Measures**

**Results**

- |   |   |   |
|---|---|---|
| 6. Monitor the splint.                          | P | F |
| 7. Check for peripheral circulation.            | P | F |
| 8. Do not cause further injury to the casualty. | P | F |

**REFERENCES:** None

**081-831-0033**

**INITIATE A FIELD MEDICAL CARD**

**CONDITIONS**

You have treated a casualty and must record the treatment given. Necessary materials and equipment: DD Form 1380 (Field Medical Card) and a pen or pencil.

**STANDARDS**

Complete, at minimum, blocks 1, 3, 4, 7, 9, and 11. Complete blocks 2, 5, 6, 8, 12, 13, 14, 15, 16, and 17 as appropriate. Complete other blocks as time permits.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Remove the protective sheet from the carbon copy.
2. Complete the minimum required blocks.
  - a. Block 1. Enter the casualty's name, rank, and complete social security number (SSN). If the casualty is a foreign military person (including prisoners of war), enter his or her military service number. Enter the casualty's military occupational specialty (MOS) or area of concentration for specialty code. Enter the casualty's religion and sex.
  - b. Block 3. Use the figures in the block to show the location of the injury or injuries. Check the appropriate box(es) to describe the casualty's injury or injuries.

*NOTE:* Use only authorized abbreviations. Except for those listed below, however, abbreviations may not be used for diagnostic terminology.

- Abr W--Abraded wound.
- Cont W--Contused wound.
- FC--Fracture (compound) open.
- FCC--Fracture (compound) open comminuted.
- FS--Fracture (simple) closed.
- LW--Lacerated wound.
- MW--Multiple wounds.
- Pen W--Penetrating wound.
- Perf W--Perforating wound.
- SL--Slight.
- SV--Severe.

*NOTE:* When more space is needed, attach another DD Form 1380 to the original. Label the second card in the upper right corner "DD Form 1380 #2." It will show the casualty's name, grade, and SSN.

- c. Block 4. Check the appropriate box.
  - d. Block 7. Check the yes or no box. Write in the dose administered and the date and time that it was administered.
  - e. Block 9. Write in the information requested. If you need additional space, use Block 14. Block 11. Initial the far right side of the block.
3. Complete the other blocks as time permits. Most blocks are self-explanatory. The following specifics are noted:
- a. Block 2. Enter the casualty's unit of assignment and the country of whose armed forces he or she is a member. Check the armed service of the casualty, that is, A/T = Army, AF/A = Air Force, N/M = Navy, and MC/M Marine.
  - b. Block 5. Write in the casualty's pulse rate and the time that the pulse was measured.
  - c. Block 6. Check the yes or no box. If a tourniquet is applied, you should write in the time and date it was applied.
  - d. Block 8. Write in the time, date, and type of IV solution given. If you need additional space, use Block 9.
  - e. Block 10. Check the appropriate box. Write in the date and time of disposition.
  - f. Block 12. Write in the time and date of the casualty's arrival. Record the casualty's blood pressure, pulse, and respirations in the space provided.
  - g. Block 13. Document the appropriate comments by the date and time of observation.
  - h. Block 14. Document the provider's orders by date and time. Record the dose of tetanus administered and the time it was administered. Record the type and dose of antibiotic administered and the time it was administered.
  - i. Block 15. The signature of the provider or medical officer is written in this block.
  - j. Block 16. Check the appropriate box and enter the date and time.
  - k. Block 17. This block will be completed by the United Ministry Team. Check the appropriate box of the service provided. The signature of the chaplain providing the service is written in this block.

***Evaluation Preparation***

*Setup:* For training and evaluation have another soldier act as a casualty and have him or her respond to the soldier's questions on personal data.

*Brief soldier:* Tell the soldier to complete the FMC by asking appropriate questions of the casualty. Tell the soldier being tested any necessary information such as the nature of the wound and the treatment given. To test step 2, you may either have the soldier complete the minimum required blocks, or you may require the completion of all blocks. After step 2 ask the soldier what must be done with each copy of the FMC.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Remove the protective sheet from the carbon copy.	P	F
2. As a minimum, complete blocks 1, 3, 4, 7, 9, and 11.	P	F
3. Make proper distribution of the FMC copies.	P	F

**REFERENCES:** None

081-831-0035

MANAGE A CONVULSIVE AND/OR SEIZING PATIENT

CONDITIONS

Necessary materials and equipment: padded tongue blade and padding materials.

STANDARDS

Complete all steps to manage a convulsive and/or seizing patient without allowing or causing unnecessary injury to the patient.

TRAINING AND EVALUATION

*Training Information Outline*

1. Identify the type of convulsion and/or seizures based upon the following characteristic signs and symptoms:

a. Petit mal.

- (1) Brief loss of consciousness without loss of motor tone.
- (2) Found chiefly in children and rarely an emergency.

b. Focal.

- (1) One part of the body (arm, leg, face) is usually involved in tonic-clonic twitching.

*NOTE:* "Tonic" is muscle tension (stiffness or rigidity). "Clonic" is the alternating contraction and relaxation of muscles in rapid succession.

(2) Motor symptoms begin in the patient's hand and/or foot and progress up the extremity or spread from the corner of the mouth.

- (3) May rapidly progress to generalized convulsions.

c. Grand mal (generalized).

- (1) May be preceded by an aura.
- (2) Loss of consciousness and intense tonic-clonic movement.
- (3) May involve incontinence, biting of the tongue, or mental confusion.

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- (4) The patient will have a stuporous or comatose period following the seizure.
- d. Status epilepticus.
  - (1) Two or more seizures without intervening period of consciousness.
  - (2) A dire medical emergency, if untreated may lead to--
    - (a) Aspiration of secretions.
    - (b) Cerebral or tissue hypoxia.
    - (c) Brain damage or death.
    - (d) Fractures of long bones.
    - (e) Head trauma.
    - (f) Injured tongue from biting.

*NOTE:* Mentally note the aspects of seizure activity for recording after the seizure.

- 2. Maintain the airway of a patient exhibiting tonic-clonic movement.
  - a. For a patient with a patent airway, insert a padded tongue blade or similar item between the patient's back teeth.

**CAUTION**

If the patient's teeth are clenched, do not attempt to forcibly open the patient's jaw.

- b. For a patient with an obstructed airway, an oropharyngeal airway should be inserted, if possible and necessary, by trained medical personnel. A patient in status epilepticus should have oxygen administered by face mask or nasal prongs.
- 3. Place the patient on his or her side, if possible.
  - a. Place the patient on his or her side, if possible.
  - b. The patient's mouth and throat should be suctioned by trained personnel, if possible.

**CAUTIONS**

1. Do not elevate the patient's head.
2. Do not restrain the patient's limbs during seizures.

4. Prevent injury to tissue and bones by padding or removing objects on which the patient may injure himself or herself.

5. Manage the patient after the convulsive state has ended.

- a. Place the patient on his side, if necessary.
- b. Continue to maintain the patient's airway.
- c. Observe for apnea (the cessation of breathing).
- d. If possible, place the patient in a quiet, reassuring atmosphere.

**CAUTION**

Sudden, loud noises may cause another seizure.

6. Record the seizure activity.

- a. Duration of the seizure.
- b. Presence of cyanosis, breathing difficulty, or apnea.
- c. Level of consciousness before, during, and after the seizure.
- d. Whether preceded by aura (ask the patient).
- e. Muscles involved.
- f. Type of motor activity.
- g. Incontinence.
- h. Eye movement.
- i. Previous history of seizures, head trauma, and/or drug or alcohol abuse.

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7. Evacuate the patient.
  - a. Position the patient on his or her side.
  - b. Arrange for the administration of oxygen or suction, if available and necessary.

***Evaluation Preparation***

*Setup:* For training and evaluation, have another soldier act as a patient.

*Brief soldier:* Tell the soldier to manage the patient.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Identify the type of convulsions and/or seizures.	P	F
2. Maintain the airway of a patient exhibiting tonic-clonic movement.	P	F
3. Place the patient on his or her side, if possible.	P	F
4. Prevent injury to tissue and bones by padding or removing objects on which the patient may injure himself or herself.	P	F
5. Manage the patient after the convulsive state has ended.	P	F
6. Record the seizure activity.	P	F
7. Evacuate the patient.	P	F
8. Do not cause further injury to the patient.	P	F

**REFERENCES:** None

081-831-0038

## TREAT A CASUALTY FOR A HEAT INJURY

### CONDITIONS

A casualty is suffering from a heat injury. No other more serious injuries or conditions are present.  
Necessary materials and equipment: water, salt, a thermometer, a stethoscope, and a sphygmomanometer.

### STANDARDS

Provide the correct treatment based upon the signs and symptoms of the injury.

### TRAINING AND EVALUATION

#### *Training Information Outline*

1. Identify the type of heat injury based upon the following characteristic signs and symptoms:
  - a. Heat cramps--muscle cramps of the arms, legs, and/or abdomen.
  - b. Heat exhaustion.
    - (1) Often--
      - (a) Profuse sweating and pale (or gray), moist, cool skin.
      - (b) Headache.
      - (c) Weakness or faintness.
      - (d) Dizziness.
      - (e) Loss of appetite or nausea.
    - (2) Sometimes--
      - (a) Heat cramps.
      - (b) Nausea (with or without vomiting).
      - (c) Urge to defecate.
      - (d) Chills.
      - (e) Rapid breathing.

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- (f) Tingling sensation of the hands and feet.
    - (g) Confusion.
  - c. Heat stroke.
    - (1) Rapid onset with the core body temperature rising to above 106 degrees F within 10 to 15 minutes.
    - (2) Hot, dry skin.
    - (3) Headache.
    - (4) Dizziness.
    - (5) Nausea (stomach pains).
    - (6) Confusion.
    - (7) Weakness.
    - (8) Loss of consciousness.
    - (9) Possible seizures.
    - (10) Pulse and respirations are weak and rapid.
- 2. Provide the proper first aid for the heat injury.
  - a. Heat cramps.
    - (1) Move the casualty to a cool shaded area, if possible.
    - (2) Loosen the casualty's clothing unless he or she is in a chemical environment.
    - (3) Give the casualty at least one canteen of salt solution. Dissolve 1/4 teaspoon (one MRE packet) of salt in one canteen of water. If salt is unavailable, give plain water.
    - (4) Evacuate the casualty if the cramps are not relieved after treatment.
  - b. Heat exhaustion.
    - (1) Conscious casualty.
      - (a) Move the casualty to a shaded area, if possible.

(b) Loosen and/or remove the casualty's clothing and boots unless he or she is in a chemical environment.

(c) Pour water on the casualty and fan him or her, if possible.

(d) Slowly give the casualty one canteen of salt solution. (See step 2a(3).)

(e) Elevate the casualty's legs.

(2) An unconscious casualty or one who is nauseated, unable to retain fluids, or whose symptoms have not improved after 20 minutes--

(a) Cool the casualty as in step 2b(1).

(b) Evacuate the casualty to an MTF for IV therapy or if qualified, initiate an IV infusion of Ringer's lactate or sodium chloride.

c. Heat stroke.

**CAUTION**

Heat stroke is a medical emergency. If the casualty is not cooled rapidly, the body cells, especially the brain cells, are literally cooked; irreversible damage is done to the central nervous system. The casualty must be evacuated to the nearest medical treatment facility immediately.

(1) Conscious casualty.

(a) Remove the casualty's outer garments and/or protective clothing, if possible.

(b) Keep the casualty out of the direct sun, if possible.

(c) Immerse the casualty in cold water, if available, and massage him or her.

(d) Lay the casualty down and elevate his or her legs.

(e) Have the casualty slowly drink at least one canteen of salt solution. (See step 2a(3).)

(f) Evacuate the casualty to an MTF for IV therapy or, if qualified, initiate an IV infusion of Ringer's lactate or sodium chloride to maintain a systolic blood pressure of at least 90 mm Hg.

(2) Unconscious casualty or one who is vomiting or unable to retain oral fluids.

(a) Cool the casualty as in step 2c(1) but give nothing by mouth.

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- (b) Initiate an IV, if qualified.
  - (c) Evacuate the casualty.
3. Record the treatment given. (See task 081-831-0033.)

***Evaluation Preparation***

*Setup:* For training and evaluation, describe to the soldier the signs and symptoms of heat cramps, heat exhaustion, or heat stroke and ask the soldier what type of heat injury is indicated.

*Brief soldier:* Ask the soldier what should be done to treat the heat injury.

***Evaluation Guide***

**Performance Measures**

- 1. Identify the type of heat injury.
- 2. Provide the proper first aid for the heat injury.
- 3. Record the treatment given.

**Results**

P	F
P	F
P	F

**REFERENCES:** None

081-831-0039

## TREAT A CASUALTY FOR A COLD INJURY

### CONDITIONS

No other more serious injuries or conditions are present. Necessary materials and equipment: dry clothing or similar material, sterile dressings, and a thermometer.

### STANDARDS

Correct treatment is provided based upon the signs and symptoms of the injury.

### TRAINING AND EVALUATION

#### *Training Information Outline*

1. Recognize the signs and symptoms of cold injuries.

a. Chilblain is caused by repeated prolonged exposure of bare skin to low temperatures from 60 degrees F down to 32 degrees F.

- (1) Acutely red, swollen, hot, tender, and/or itching skin.
- (2) Surface lesions with shedding of dead tissue, or bleeding lesions.

b. Frostbite is caused by exposure of the skin to cold temperatures that are usually below 32 degrees F depending on the windchill factor, length of exposure, and adequacy of protection.

*NOTE:* The onset is signaled by a sudden blanching of the skin of the nose, ears, cheeks, fingers, or toes followed by a momentary tingling sensation. Frostbite is indicated when the face, hands, or feet stop hurting.

(1) Superficial (first and second degree).

(a) Redness of the skin in light-skinned individuals and grayish coloring of the skin in dark-skinned individuals, followed by a flaky sloughing of the skin.

(b) Blister formation 24 to 36 hours after exposure followed by sheet-like sloughing of the superficial skin (second degree).

(2) Deep.

(a) Loss of feeling.

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- (b) Pale, yellow, waxy look if the affected area is unfrozen.
- (c) Solid feel of the frozen tissue.
- (d) Blister formation 12 to 36 hours after exposure unless rewarming is rapid.
- (e) Appearance of red-violet discoloration 1 to 5 days after the injury.

*NOTE:* Gangrene and residual nerve damage will result without proper treatment.

c. Generalized hypothermia is caused by prolonged exposure to low temperatures, especially with wind and wet conditions, and it may be caused by immersion in cold water.

**CAUTION**

With generalized hypothermia, the entire body has cooled with the core temperature below 95 degrees F. This is a medical emergency.

- (1) Moderate hypothermia.

*NOTE:* This condition should be suspected in any chronically ill person who is found in an environment of less than 50 degrees F.

- (a) Conscious, but usually apathetic or lethargic.
  - (b) Shivering, with pale, cold skin.
  - (c) May have acetone scent to breath.
- (2) Severe hypothermia.
    - (a) Unconscious or stuporous.
    - (b) Ice cold skin.
    - (c) Inaudible heart beat.
    - (d) Unobtainable blood pressure.
    - (e) Unreactive pupils.
    - (f) Very slow respirations.

d. Immersion syndrome (immersion foot, trench foot and hand) is caused by fairly long (hours to days) exposure of the feet or hands to wet conditions at temperatures from about 50 degrees F down to 32 degrees F.

(1) First phase (anesthetic)

(a) There is no pain sensation, but the affected area feels cold.

(b) The pulse is weak at the affected area.

(2) Second phase (reactive hyperemic)--limbs feel hot and/or burning and have shooting pains.

(3) Third phase (vasospastic)--

(a) Affected area is pale.

(b) Cyanosis.

(c) Pulse strength decreases.

(4) Check for blisters, swelling, redness, heat, hemorrhage, or gangrene.

e. Snow blindness.

(1) Scratchy feeling in the eyes as if from sand or dirt.

(2) Watery eyes.

(3) Pain, possibly as late as 3 to 5 hours later.

(4) Reluctant or unable to open eyes.

2. Treat the cold injury.

a. Chilblain.

(1) Apply local rewarming within minutes.

(2) Protect lesions (if present) with dry sterile dressings.

**CAUTION**

Do not treat with ointments.

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b. Frostbite.

- (1) Apply local rewarming using body heat.

**CAUTION**

Avoid thawing the affected area if it is possible that the injury may refreeze before reaching the treatment center.

- (2) Loosen or remove constricting clothing and remove jewelry.
- (3) Increase insulation and exercise the entire body as well as the affected body part(s).

**CAUTION**

Do not massage the skin or rub anything on the frozen parts.

- (4) Move the casualty to a sheltered area, if possible.
- (5) Protect the affected area from further cold or trauma.
- (6) Evacuate the casualty.

*NOTE:* For frostbite of a lower extremity, evacuate the casualty by litter, if possible.

**CAUTION**

Do not allow the casualty to use tobacco or alcohol.

c. Generalized Hypothermia.

- (1) Moderate.
  - (a) Remove the casualty from the cold environment.
  - (b) Replace wet clothing with dry clothing.
  - (c) Cover the casualty with insulating material or blankets.

- (d) If available, apply heating pads to the casualty's armpits, groin, and abdomen.

*NOTE:* If far from a medical treatment facility and the situation and facilities permit, immerse the casualty in a tub of 105 degree F water.

- (e) If available, give sugar and sweet warm fluids.

**CAUTION**

Do not give the casualty alcohol.

- (f) Wrap the casualty from head to toe.

- (g) Evacuate the casualty lying down.

- (2) Severe.

**CAUTION**

Handle the casualty very gently.

- (a) Cut away wet clothing and replace it with dry clothing.

- (b) Maintain the airway. (See task 081-831-0018.)

- 1) Administer oxygen if trained personnel and equipment are available.

- 2) Assist with ventilation if the casualty's respiration rate is less than five per minute.

*NOTE:* Do not use artificial airways or suctioning devices.

**CAUTION**

Do not hyperventilate the casualty. Keep the rate of artificial ventilation at approximately 8 to 10 per minute.

- (c) Monitor the heartbeat. (See task 081-831-0011.) If none is detected, begin CPR. (See tasks 081-831-0046 and 081-831-0048.)

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(d) Evacuate the casualty positioned on his or her back with the head in a 10 degree head-down tilt.

*NOTE:* The treatment of moderate hypothermia is aimed at preventing further heat loss and rewarming the casualty as rapidly as possible. Rewarming a casualty with severe hypothermia is critical to saving his or her life, but the kind of care rewarming requires is nearly impossible to carry out in the field. Evacuate the casualty promptly to a medical treatment facility. Use stabilizing measures en route.

d. Immersion syndrome.

(1) Dry the affected part immediately and gradually rewarm it in warm air.

### CAUTION

Never massage the skin. After rewarming the affected part, it may become swollen, red, and hot. Blisters usually form due to circulation return.

(2) Protect the affected part from trauma and secondary infection.

(3) Elevate the affected part.

(4) Evacuate the casualty as soon as possible.

e. Snow blindness. Cover the eyes with a dark cloth and evacuate the casualty to a medical treatment facility.

### *Evaluation Preparation*

*Setup:* For training and evaluation have another soldier act as the casualty. Select one of the types of cold injuries on which to evaluate the soldier. Coach the simulated casualty on how to answer questions about symptoms. Physical signs and symptoms that the casualty cannot readily simulate, for example blisters, must be described to the soldier.

*Brief soldier:* Tell the soldier to determine what cold injury the casualty has. After the cold injury has been identified, ask the soldier to describe the proper treatment.

### *Evaluation Guide*

#### **Performance Measures**

1. Identify the type of cold injury.

P F

2. Provide the proper first aid treatment for the injury.

P F

*NOTE:* Although not evaluated, the soldier would record the treatment given on the appropriate form and evacuate the casualty as necessary.

**REFERENCES:** None

081-832-0062

**COLLECT COLLATERAL INFORMATION FROM RECORDS**

**CONDITIONS**

You are preparing to conduct an information gathering interview. You need additional or corroborative information to clarify the presenting problem. Necessary materials: SF 600.

**STANDARDS**

Correctly summarize and record all collateral information on SF 600.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

- |  |   |   |
|--|---|---|
| 1. Identify which records provide the necessary information to-- | P | F |
| a. Further define the presenting problem.                        |   |   |
| b. Corroborate information provided by the client.               |   |   |

*NOTE:* Information may be collected from various sources such as medical, law enforcement, military personnel, family advocacy, drug and alcohol, psychiatric, and exceptional family member program records.

- |   |   |   |
|---|---|---|
| 2. Obtain the client's permission to review the records, as required by regulation.       | P | F |
| a. The client's permission is not required for command referred clients.                  |   |   |
| b. The client's permission is required for self-referred soldiers and for family members. |   |   |

- |  |   |   |
|--|---|---|
| 3. Obtain records in accordance with the appropriate regulation. | P | F |
|--|---|---|

*NOTE:* Skill level one soldiers should coordinate this step with their supervisor.

- |  |   |   |
|--|---|---|
| 4. Extract pertinent information.                              | P | F |
| 5. Record an information summary in the client's case record-- | P | F |
| a. Accurately.   |   |   |

**Performance Measures**

**Results**

- b. Chronologically, or by subject area.
- c. In the proper location.

(1) Record in the "Referral Data" section the information collected as part of an intake interview.

(2) Record in the "Objective" section of the progress notes the information collected as part of subsequent interviews.

6. File copies of the collateral records chronologically on the left-hand side of the case file.

P F

**REFERENCES:**

*Required*

*Related*

None

- AR 25-55
- AR 340-21
- AR 600-85
- AR 608-18
- AR 930-5

**081-832-0063**

**CONDUCT AN INFORMATION GATHERING INTERVIEW**

**CONDITIONS**

You are required to interview a client and record the results of the interview. Necessary materials: notepaper, SF 600, consultation request or referral form, and completed client personal data questionnaire.

**STANDARDS**

Define the presenting problem and obtain relevant background information using appropriate interview techniques. Record the interview in topical outline format with relevant information under appropriate headings.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Prepare for the interview.
  - a. Review all available information such as the client's personal data questionnaire, referral form, and collateral information.
  - b. Identify and list background information and potential problem areas to be explored during the interview.
  - c. Arrange the setting.
    - (1) Maximize privacy and freedom from distraction.
    - (2) Arrange furniture in a manner which allows for easy eye contact. Provide the client with adequate leg and foot room. Allow for a physical distance of 3 to 5 feet between you and the client. This will allow you to write without turning your body away from the client.
2. Establish a working relationship with the client.
  - a. Address the client by rank or title and name. Introduce yourself by rank and name.
  - b. Show the client to the interview area and invite the client to be seated comfortably.
  - c. Explain to the client--
    - (1) The role of the agency, your job title, your role as an interviewer, and review the Privacy Act and get the client's signature.

- (2) The types of questions you will ask and the kinds of information you will gather.
- (3) The approximate time the interview will require--about 45 to 60 minutes.
- (4) Administrative and staffing procedures which may affect the client.

*NOTES:* 1. If the client starts to express himself or herself during your explanation, allow the client to continue and establish your working relationship at a later time.

2. If the client expresses concern regarding confidentiality, explain that information from the interview is shared with professional supervisors and others who have "an official need to know." If the client starts to divulge activities in violation of Army regulations, caution the client that the military does not protect interviewer/client privileged communication.

- d. Resolve any questions the client may have about the interview.
- e. Inform the client that you may be taking some notes and he or she is free to look at them after the interview.

3. Establish rapport.

- a. Encourage the client to talk by asking routine, nonthreatening questions to verify personal history data.
- b. Demonstrate empathy with the client.

*NOTE:* Empathy is the ability to understand people from their frame of reference, rather than your own. Empathy lets the client know you desire to understand his or her feelings.

- (1) Recognize the client's expression of emotions.
  - (2) Respond with sensitivity to the client's full range and intensity of feelings.
  - (3) Give open, honest responses.
- c. Display "objective" but "interested" behavior.
- (1) Do not judge.
  - (2) Treat the client as an equal.
  - (3) Show respect and acceptance for the client's feelings.
  - (4) Maintain direct eye contact.

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- (5) Sit in an attentive posture.
- d. Encourage the client to talk freely about the problem.
- 4. Employ appropriate interview techniques.
  - a. Use appropriate questioning techniques.
    - (1) Initiate the conversation by extending an open invitation to the client to express his or her views and feelings.
    - (2) Use single, brief, concisely stated questions to encourage response to one idea.
      - (a) Use open-ended questions to get the client to discuss a topic at length.

EXAMPLES: "How would you describe your father?"  
"What was your reaction to that situation?"

- (b) Use closed-ended questions to get brief factual responses.

EXAMPLES: "How old are you?"  
"Do you like your job?"

- (c) Use vocabulary and construction of questions tailored to the client's level of comprehension.
  - (3) Keep the interview moving by not dwelling on areas already explored.
  - (4) Keep the interview on target by asking pertinent questions and preventing digressions.
- b. Use appropriate attentive listening techniques.
  - (1) Use reflections to summarize and verify the client's feelings. For example, a client says that one moment he or she hates someone and loves them the next. To reflect his or her feelings, you might respond by saying that you feel all confused.
  - (2) Use paraphrasing to summarize and verify the client's response content. For example, a client says that one moment he or she hates someone and loves them the next. To paraphrase you might respond by saying that your feelings towards your loved one keep changing.
  - (3) Be aware of verbal cues which might indicate a significant area to be explored.
  - (4) Use silence of short durations to stimulate effective client response.
- 5. Elicit information from the client to define the presenting problem.

- a. Ask the client to describe in his or her own words the nature of the problem.
- b. Compare the stated description of the problem with the written description in the personal data questionnaire. If there are any discrepancies, ask the client to explain.
- c. Elicit the following information from the client:
  - (1) The client's perception of the problem.
    - (a) Reasons for the problem, the time of onset and life circumstances at that time, and the frequency, severity, and duration of the problem.
    - (b) Social, physical, and emotional effects on the client.
    - (c) Impact on the client's ability to function.
    - (d) Client's behavior in the situation.
    - (e) Setting(s) in which the behavior occurs.
    - (f) Social, physical, and emotional effects on significant others.
  - (2) The client's attitude toward resolving the problem.
    - (a) Acceptance of the problem.
    - (b) Acceptance of responsibility for the problem.
    - (c) Motivation to resolve the problem.
  - (3) Coping techniques used in previous attempts to resolve the problem.
  - (4) Successes and failures in trying to resolve the problem.
  - (5) Possible solutions defined by the client.
  - (6) What prompted the client to seek help at this time.
  - (7) How the client believes other people perceive his or her problem.
  - (8) Concerns other than the original presenting problem.

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### 6. Obtain relevant background information.

*NOTE:* Select those areas which have immediate bearing on the presenting problem. These areas should place the presenting problem into a perspective that will increase understanding. The areas listed are guidelines and are not all inclusive.

- a. Family history.
  - (1) Type of family (nuclear, extended, single parent, step, adoptive).
  - (2) Cultural values.
  - (3) Composition of family members.
  - (4) Socioeconomic conditions.
  - (5) History of mental disorders or psychological problems.
- b. Occupational history.
  - (1) Types of jobs.
    - (a) Civilian.
    - (b) Military.
  - (2) Stability of employment.
    - (a) Layoffs.
    - (b) Frequent job changes.
    - (c) Financial security.
  - (3) Job achievements and failures.
    - (a) Job satisfaction.
    - (b) Relationship with coworkers.
    - (c) Goal achievement.
- c. Medical history.
  - (1) Significant injuries and illnesses.

- (2) Physical fitness.
- d. Marital history.
  - (1) History of previous marriages and divorces.
  - (2) Length and quality of the marriages.
  - (3) Problems in communication.
  - (4) Sexual compatibility.
  - (5) Child rearing practices interfering with the marriages.

*NOTE:* Other related background areas may be added if they are pertinent to the client's problem, for example, substance abuse, law enforcement, legal and disciplinary problems, educational, recreational activities, psychiatric, and sexual history.

- 7. Assess social functioning. (See task 081-832-0006.)
- 8. Assess mental status. (See task 081-832-0005.)
- 9. Terminate the interview.
  - a. Summarize the main points covered in the interview.
  - b. Obtain feedback from the client to verify the accuracy of points covered.
  - c. Inform the client of the disposition alternatives.
    - (1) Referral to another agency or staff member.
    - (2) Reason for referral.
    - (3) Continue follow-up services at the intake agency.
    - (4) Recommendations and anticipated plans for treatment.
    - (5) Consultation with your supervisor.
  - d. Encourage the client to participate in the selection of disposition alternatives.
  - e. If the client is to be referred to another individual or agency, complete the referral form. (See task 081-832-0007.)

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f. If the client is to return for follow-up, discuss arrangements for making another appointment and provide him or her with an appointment slip.

g. Inform the client of emergency services which are available.

h. Ask the client if he or she has any questions.

i. Escort the client to the exit.

10. Record the interview.

*NOTE:* Use third person, past tense, and type or write all information in black or blue-black ink.

a. Use SF 600.

b. In the patient identification block, include the following information: name, sex, year of birth, component, and social security number. If the client is a family member of a service member, include the sponsor's name, social security number, and relationship to the sponsor. Use a pencil to record the client's rank and grade and organization.

c. Fill in the date of the entry in the column titled "Date." The date should be on the first line used for the entry.

d. Include the following information in the column titled "Symptoms, Diagnosis, Treatment, Treating Organization":

(1) Identification Data. This section should include the client's name, rank, age, sex, race, social security number, MOS code and duty title, unit of assignment, length of service, component, marital status, and religious preference.

(2) Referral Data. This section should include the referral source, date, reason, service requested, and collateral information (source, content, and date the information was obtained).

(3) Statement of Problem. This section should include the client's perception of the problem and attitude toward it; the time of onset, frequency, severity, and duration; the social, physical, and emotional effects and how they each contrast with the premorbid state; effects on significant others; and the client's previous attempts to resolve the problem.

(4) Background Information. This section should include relevant information and history in each of the major following areas: family, occupational, medical, and marital. Other related areas may include substance abuse, law enforcement, legal and disciplinary problems, educational, recreational activities, psychiatric, and sexual history.

(5) Mental Status. This section should include information based upon a mental status evaluation. (See task 081-832-0005.)

(6) Specialist's Impressions. This section should include your impression of the problem to include a behavioral description and a diagnostic label of what the problem appears to be.

- (a) Acute--refers to any problem that has lasted less than three months.
- (b) Chronic--refers to any problem that has lasted longer than three months.
- (c) Focal--client's life is significantly affected by one area of his or her life, for example, his or her family.
- (d) General--client's life is significantly affected by more than one area of his or her life, for example, family, marital, and occupational.
- (e) Precipitating events--what situations made the client seek assistance with the presenting problem.
- (f) Contributory internal factors--the client's feelings, needs, and desires toward some object or person associated with the problem.
- (g) Psychosocial stressors--external events affecting the client's life associated with the problem such as major illness, bankruptcy, or marital status.
- (h) Clients' ability to cope based on past experiences and present situation.
- (i) Stress difficulties related by the client.
- (j) Motivation to act and to resolve the problem.
- (k) Support systems--refers to family, coworkers, friends, and unit used by the client to assist with the resolution of the problem.
- (l) Prior level of functioning. (See task 081-832-0006.)
- (m) Recommendation for resolution.

(7) Disposition. If the client is referred to another agency, include the name of the agency, time and date of appointment, person contacted, service requested, follow-up efforts, and staffing of the case. If the client is to return to the clinic, include the time and date of appointment, the name of the staff member who will see the client, the reason for the appointment, and staffing of the case. If the case is terminated, include a full explanation of the reasons for termination.

- e. Sign your name on the line following your disposition entry.
- f. On the line following your signature, include your name, rank, and MOS title--Mental Health Specialist.

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- g. Utilize the following recording principles:
- (1) Use the rules of grammar, punctuation, and spelling.
  - (2) Authenticity. Facts and opinions are identified and reported separately. Quotes are verbatim.
  - (3) Brevity. Redundancy and verbiage are avoided.
    - (a) Use concise wording which provides a complete description.
    - (b) Avoid acronyms and abbreviations.
  - (4) Clarity. Statements are exact and precise, leaving no doubt as to the meaning. Slang is avoided.
  - (5) Relevance. Statements, comments, and conclusions are relevant to the client's case. Record topics in detail as determined by their relationship to the presenting problem.

### *Evaluation Preparation*

*Setup:* Tasks 081-832-0006 and 081-832-0005 should be evaluated at the same time that this task is evaluated. Each of the three tasks will be scored independently.

*NOTE:* If other tasks will be evaluated at the same time as the information gathering interview, tell the soldier during the briefing.

*Brief soldier:* Tell the soldier to conduct an information gathering interview. Tell him or her that the portions of the interview procedure dealing with assessments of social functioning and mental status will be scored separately.

### *Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Prepare for the interview.	P	F
2. Establish a working relationship with the client.	P	F
3. Establish rapport.	P	F
4. Employ appropriate interview techniques.	P	F
5. Elicit information from the client to define the presenting problem.	P	F

**Performance Measures**

**Results**

6. Obtain relevant background information.

P F

*NOTE:* Evaluate the soldier on assessing social functioning and mental status at this time.  
(See tasks 081-832-0006 and 081-832-0005.)

7. Assess social functioning.

P F

8. Assess mental status.

P F

9. Terminate the interview.

P F

10. Record the interview.

P F

**REFERENCES:**

*Required*

None

*Related*

AR 25-55  
AR 340-21  
AR 600-85  
AR 608-18

**081-832-0011**

**CONDUCT A COLLATERAL INTERVIEW**

**CONDITIONS**

You have conducted an information gathering interview and need to interview a third person to substantiate and expand on the information obtained. Necessary materials: client's case file, SF 600, notepaper, and access to a telephone.

**STANDARDS**

Obtain and accurately record all relevant information.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Plan for the interview.
  - a. Review the case record and list areas to be discussed with the resource person.
    - (1) Further define the presenting problem.
    - (2) Corroborate information provided by the client.
  - b. Identify the appropriate source of information--one who you would expect to have knowledge of the client's current or past situation.
    - (1) Supervisors and commanders may provide information related to a soldier's military performance.
    - (2) Family members may provide information related to a soldier's domestic problems.
    - (3) Medical personnel may provide information related to a soldier's medical problems.
    - (4) Creditors may provide information related to a soldier's financial problems.

*NOTE:* Often one of the sources identified may have information regarding another source's area of expertise. For example, family members may have valuable information regarding medical problems.

- c. Obtain the client's permission to interview the collateral resource, if required by regulation.
  - (1) The client's permission is not required for command referred clients.

- (2) The client's permission is required for self-referred soldiers and family members.
- d. Make an appointment with the collateral resource to see him or her in person.
- 2. Establish rapport.
  - a. Be punctual.
  - b. Exercise proper courtesy.
  - c. Explain the purpose of the interview, your role, and that of the agency you represent.
- 3. Employ appropriate interviewing and attentive listening techniques.
  - a. Move the interview systematically through the opening, middle, and closing stages.
  - b. Use reflection to summarize and verify the collateral resource's feelings.
  - c. Use paraphrasing to summarize and verify statements made by the collateral resource.
  - d. Use questioning techniques appropriate for obtaining the desired information.
    - (1) Clear questions--tailored to the collateral resource person's level of comprehension.
    - (2) Open-ended questions--invite the collateral resource person to talk freely about the client.
    - (3) Closed-ended questions--elicit the collateral resource person to answer in a brief, factual manner.
    - (4) Single questions--encourage the collateral resource person to respond directly to one idea.
- 4. Obtain necessary information.
  - a. Identification data of the collateral resource person.
    - (1) Name.
    - (2) Rank (if military).
    - (3) Telephone number.
    - (4) Organization or address.
  - b. Identify the collateral resource person's relationship to the client.

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- c. Elicit information to define the collateral resource person's perception of the client's problem.
  - (1) Time of onset.
  - (2) Client's previous attempts to deal with the problem.
    - (a) Client's coping techniques.
    - (b) Client's successes and failures in trying to resolve the problem.
  - (3) Effects of the client's problem on significant others.
    - (a) Physical.
    - (b) Social.
    - (c) Emotional.
  - (4) Effects of the problem on the client.
    - (a) Physical.
    - (b) Social.
    - (c) Emotional.

*NOTE:* It is essential that only that information the collateral resource person needs to know about the client is discussed.

5. Summarize the main points covered in the interview to verify the content.

*NOTES:* 1. Steps 2 through 5 may be done telephonically if the collateral resource person is known to you, but they should be done in person when possible.

2. Take brief notes which should be expanded after terminating the interview.

6. Record information obtained as part of subsequent interviews in the "Objective" section of the progress notes.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Plan for the interview.	P F
2. Establish rapport.	P F
3. Employ appropriate interviewing techniques.	P F
4. Obtain the necessary information.	P F
5. Summarize the main points of the interview.	P F
6. Record the information obtained accurately.	P F

**REFERENCES:**

*Required*

None

*Related*

AR 25-55  
 AR 340-21  
 AR 600-85  
 AR 608-18

081-832-0013

**PRESENT A CASE FOR SUPERVISION**

**CONDITIONS**

You have identified a case which requires supervision. Necessary materials: client's case file, SF 600, and notepaper.

**STANDARDS**

Present the case for staffing in a well-organized manner to include all required information.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

1. Determine whether the case requires immediate or prompt supervision.

P F

*NOTE:* All cases will be staffed with your supervisor.

- a. Criteria for immediate supervision.

*NOTE:* Cases requiring immediate supervision must be staffed before the client leaves the clinic.

- (1) High suicide potential.
- (2) High homicide potential.
- (3) Psychosis.
- (4) High potential to be physically dangerous.

- b. Criteria for prompt supervision.

*NOTE:* Cases requiring prompt supervision should be staffed prior to the client's return appointment.

- (1) Cases that involve violations of legal statutes.
- (2) Cases that the Mental Health Specialist lacks the skills to handle.

<b>Performance Measures</b>	<b>Results</b>
(3) Cases that the Mental Health Specialist feels uncomfortable with.	
2. Prepare for staffing.	P F
a. Review the case record.	
b. List the significant areas needed to present the case.	
3. Present the information orally using the following format:	P F
a. Client's identification data.	
b. Referral data.	
c. Brief statement of the client's problem.	
d. Relevant background information.	
e. Significant mental status aspects.	
f. Progress notes.	
g. Specialist's impressions.	
(1) Social and psychological functioning.	
(2) Supported, substantiated facts written in the case record.	
h. Recommended disposition.	
(1) Alternatives discussed and the basis for their acceptance or rejection.	
(2) Impressions and facts in the case record which support the disposition alternatives.	
4. Take notes regarding the supervisor's comments.	P F
5. Record the staffing procedure to include the following information:	P F
a. Date of case presentation.	
b. Supervisor's name.	

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**Performance Measures**

**Results**

- c. Suggestions made by the supervisor.
- d. Specialist's intended actions.

*NOTE:* This information should be recorded in the "Disposition" section if the case is an intake interview or in the "Objective" section of the progress notes if the case is on-going.

- 6. The supervisor should sign the client case record after reviewing the case.

P F

**REFERENCES:** None

081-832-0005

## ASSESS A CLIENT'S MENTAL STATUS

### CONDITIONS

You are required to interview a client and assess the client's mental status. Necessary materials: notepaper and SF 600.

### STANDARDS

Record the assessment of the client's mental status in an ordered, narrative style. Include appropriate comments, justifying the conclusions drawn, in all assessments.

### TRAINING AND EVALUATION

#### *Training Information Outline*

*NOTE:* The areas of assessment listed below are not all inclusive.

1. Assess the client's appearance.
  - a. Client is unclean, unkempt, or overly meticulous.
  - b. Clothing is dirty, disheveled, has missing items such as buttons or insignias, or is unusually neat.
  - c. Clothing is atypical, unusual, or bizarre.
  - d. Client has unusual physical characteristics such as bruises, scars, burns, tattoos, blindness, broken arm, obesity, or physical deformities.
  - e. Client appears much older or younger than his or her stated age.
2. Assess the client's behavior.
  - a. Posture is relaxed, tense, rigid, slumped, recumbent, atypical, or inappropriate.
  - b. Facial expressions display anxiety, apprehension, fear, anger, hostility, sadness, depression, decreased variability of expression, bizarreness, or inappropriateness.
  - c. Body movements are accelerated, slowed, repetitive, peculiar, inappropriate, restless, or anxious.
  - d. Speech patterns are abnormal in--
    - (1) Quality--rate of production, volume, pitch, tone, and pronunciation.

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- (2) Quantity--poverty of speech, monosyllabic answers, and pressure of speech.
- (3) Organization--poverty of content of speech, circumstantiality, tangentiality, incoherence, clanging, echolalia, perseveration, flight of ideas, and loosening of associations.
  - (a) Poverty of content of speech--adequate in amount but vague, empty, or obscure.
  - (b) Circumstantiality--indirect and delayed because of tedious, unnecessary details.
  - (c) Tangentiality--replying in an irrelevant manner.
  - (d) Incoherence--not understandable, no meaningful connections, excessive irrelevancies, or abrupt changes.
  - (e) Clanging--sounds govern word choices. May include puns or rhyming.
  - (f) Echolalia--repetition of the words or phrases of others.
  - (g) Perseveration--persistent repetition of particular words, subjects, or ideas.
  - (h) Flight of ideas--continuous but fragmented speech with abrupt changes.
  - (i) Loosening of associations--shifting between unrelated subjects without awareness of doing so.
- e. Client and interviewer interaction is cooperative, friendly, interested, trusting, attentive, guarded, suspicious, evasive, defensive, uncooperative, hostile, domineering, ingratiating, provocative, or seductive.
- f. Poor eye contact or excessive staring.

*NOTE:* The client's behavior sometimes varies significantly with the topic being discussed. If this occurs, it should be noted.

3. Assess the client's emotional state.
  - a. Appropriate or inappropriate to thought content.
  - b. Affect is normal, blunted, flat, or labile.
    - (1) Blunted--a severe reduction in intensity.
    - (2) Flat--absence or near absence of any signs of affect.
    - (3) Labile--rapid emotional changes unrelated to emotional stimuli.
  - c. Mood is normal, dysphoric, elated, euphoric, or irritable.

- (1) Dysphoric--unpleasant sense of being.
  - (2) Elated--feeling of joy.
  - (3) Euphoric--exaggerated sense of emotional or physical well-being.
  - (4) Irritable--easily upset.
4. Assess the client's perceptual functioning.
- a. Presence or absence of illusions, hallucinations, or depersonalization.
    - (1) Illusions--misperception of a real external stimulus.
    - (2) Hallucinations--false sense of perceptions in the absence of actual external stimulus.
    - (3) Depersonalization--feelings of unreality or strangeness concerning the environment and oneself.
  - b. Contents and circumstances under which they occur.
5. Assess the client's cognitive functioning.
- a. Orientation to person, place, time, and situation.
  - b. Memory is intact, or immediate recall and recent and remote memory is impaired.
  - c. Client is attentive or easily distracted.
  - d. Estimation of intelligence as evidenced by general knowledge, sophistication of vocabulary, level of education, abstract thinking, and calculation ability.
  - e. Estimation of judgment as evidenced by the client's ability to evaluate a problem situation and to respond in a practical and socially acceptable manner.
  - f. Estimation of insight as evidenced by the degree of awareness that problems exist and the degree to which he or she contributes to the situation.
  - g. Thought process is intact or fragmented by blocking or loose associations and whether thought flow is decreased or increased.
  - h. Thought content is normal or characterized by phobias, obsessions, compulsions, delusions, ideas of reference, ideas of influence, suicidal ideation, homicidal ideation, paranoid ideation, magical thinking, repetitive themes, somatic complaints, or poor self-image.

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6. Record the assessments.

a. Describe the following impressions and observations of the client in the following order using a narrative style:

- (1) Appearance.
- (2) Behavior.
- (3) Emotional state.
- (4) Perceptual functioning.
- (5) Cognitive functioning.

b. If the interview is an intake interview, record the assessments in the "Mental Status" section of the intake recording.

c. If the interview is a follow-up interview, record the assessments in the "Objective" section of the progress notes.

d. Include comments that justify the conclusions drawn.

***Evaluation Guide***

**Performance Measures**

**Results**

*NOTE:* This task should be evaluated in conjunction with task 081-832-0063.

1. Assess the client's appearance.	P	F
2. Assess the client's behavior.	P	F
3. Assess the client's emotional state.	P	F
4. Assess the client's perceptual functioning.	P	F
5. Assess the client's cognitive functioning.	P	F
6. Record the assessments in a narrative style.	P	F

**REFERENCES:** None

081-832-0006

**ASSESS A CLIENT'S SOCIAL FUNCTIONING**

**CONDITIONS**

You are conducting an information gathering interview, and you have elicited information about social and occupational functioning. Necessary materials: SF 600 and notepaper.

**STANDARDS**

Make an accurate assessment of the quality of current and past social functioning and record the information, to include supporting criteria.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

*NOTES:* 1. This task should be evaluated in conjunction with task 081-832-0063.  
 2. The current level of social and occupational functioning is determined as it pertains to the client's present situation or presenting problem. The previous level of functioning should indicate how the client was functioning prior to the present situation or presenting problem.

- |   |               |
|---|---------------|
| <ol style="list-style-type: none"> <li>1. Evaluate the client's current and past social functioning based on the following areas:                     <ol style="list-style-type: none"> <li>a. Personal.                             <ol style="list-style-type: none"> <li>(1) Physical care.</li> <li>(2) Psychosocial development.</li> <li>(3) Acceptance of self.</li> <li>(4) Adaptation to stress.</li> <li>(5) Impulse control.</li> <li>(6) Productivity.</li> <li>(7) Involvement in activities of personal growth.</li> </ol> </li> </ol> </li> </ol> | <p>P    F</p> |
|---|---------------|

**Performance Measures**

**Results**

- b. Family.
  - (1) Relationship with parents.
  - (2) Relationship with siblings.
  - (3) Relationship with current or former spouse.
    - (a) Quality of communication.
    - (b) Quality of time.
    - (c) Marital satisfaction.
    - (d) Adaptation to marital stressors.
  - (4) Relationship with children.
    - (a) Quality of communication.
    - (b) Quality of time.
    - (c) Response to children's physical, social, and psychological needs.
- c. Other interpersonal relationships.
  - (1) Choice and quality of relationship with friends.
  - (2) Amount and type of involvement with community members, other membership group organizations, associates, and authority figures.
- 2. Utilize background information obtained from social and occupational functioning areas to increase understanding of the current problem. P F
- 3. Evaluate the client's current and past occupational functioning. P F
  - a. Educational.
    - (1) Highest level completed.
    - (2) Academic performance.
    - (3) Adjustment to school.

**Performance Measures**

**Results**

- (4) Relationship with students, teachers, and administrators.
- (5) Involvement in school activities.

b. Occupational.

- (1) Relationship with coworkers, subordinates, supervisors, and management.
- (2) Job satisfaction.
- (3) Job performance.
- (4) Frequency of job changes.
- (5) Achievements and failures.
- (6) Career goals.
- (7) Financial stability.

*NOTE:* When evaluating social and occupational functioning, the client's entire life cycle should be considered.

4. Assess social and occupational functioning as good, fair, or poor in all areas listed in 1a through 1c, and 3a and 3b above. P    F

a. Determine functioning as good based on--

- (1) Absence of or minimal presence of psychological and physical symptoms affecting the client.
- (2) Impairment of interpersonal relationships limited to occasional problems such as arguments with family members.
- (3) Client's general satisfaction and success with life.
- (4) Client's interest and involvement in a wide range of activities.

b. Determine functioning as fair based on--

- (1) Psychological and physical symptoms moderately affecting the client such as depression, restlessness, or difficulty concentrating.

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**Performance Measures**

**Results**

- (2) Impaired family, marital, occupational, and other interpersonal relationships.
- (3) Involvement in minor violations of the law.
- c. Determine functioning as poor based on--
  - (1) Serious psychological and physical symptoms affecting the client such as suicidal ideation and attempts, extreme anxiousness, and passive or aggressive actions.
  - (2) Serious impairment in personal, family, educational, and occupational functioning.
- 5. Record the assessment in the "Specialist's Impressions" section of the interview recording, to include supporting criteria.

P F

**REFERENCES:** None

081-832-0064

## ASSESS CLIENT PSYCHOPATHOLOGY

### CONDITIONS

You are under clinical supervision and have been instructed to interview a client to identify indicators of psychopathology. Necessary materials: notepaper, client's collateral information, and SF 600.

### STANDARDS

Observe psychopathological behavior and classify the mental disorder as Functional or Organic. Record the impressions and observations and provide them to the clinical supervisor with the appropriate recommendations.

### TRAINING AND EVALUATION

#### *Training Information Outline*

1. Review collateral information.
2. Interview the client. (See task 081-832-0063.)
3. Assess the client for Psychopathological Disorders--manifestations of mental disorders.
  - a. Identify the presence of the characteristics of Functional Disorders-mental disorders in which no organic cause has been identified. (Personality Disorders, Anxiety Disorders, Somatoform Disorders, Dissociative Disorders, Mood Disorders, Schizophrenic Disorders, Paranoid Disorders, Adjustment Disorders, Sexual Disorders, and Psychotic Disorders not covered elsewhere.)
    - (1) Personality Disorders.
      - (a) Life-long pattern of inflexible, maladaptive personality traits.
      - (b) Significant impairment in social or occupational functioning.
      - (c) Little or no motivation to change behavior.
      - (d) Behaviors occur by adolescence or early adulthood.
      - (e) Behaviors continue throughout adult life and diminish in middle or old age.
      - (f) Recommended treatment and management options include group therapy, consultation with the client's supervisor, and military administrative action.

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### (2) Anxiety Disorders.

- (a) Feeling of apprehension, tension, or uneasiness from the anticipation of danger, which may be internal or external.
- (b) Avoids anxiety provoking places or situations.
- (c) Usually identifiable in childhood or adolescence.
- (d) Exhibits symptoms such as obsessions, compulsions, or phobias which elicit emotional discomfort (primarily anxiety, sometimes depression).
- (e) No loss of contact with reality.
- (f) No gross personality disorganization.
- (g) Recommended treatment and management options include group therapy and marital counseling.

### (3) Somatoform Disorders.

- (a) Physical symptoms that suggest a physical disorder, but show no organic cause.
- (b) Symptoms are linked to psychological factors.
- (c) Symptoms are not intentionally produced.
- (d) Emotional discomfort is often experienced along with the physical complaints, except in a few instances where there seems to be a complete indifference to the physical symptoms.
- (e) No loss of contact with reality.
- (f) No gross personality disorganization.
- (g) Clients suffering from this condition often refuse to be seen in mental health facilities for treatment.

### (4) Dissociative Disorders.

- (a) Disturbance or change in the normally integrative functions of identity, memory, or consciousness.
- (b) Onset may be sudden, gradual, transient, or chronic.

(c) If occurrence is mainly in identity, an individual's identity is temporarily forgotten and a new one is assumed.

(d) Client's customary feeling of his or her own reality is lost and replaced by a feeling of unreality.

(e) If the occurrence is primarily in memory, important events can not be remembered.

(f) Recommended treatment and long term management is long term mental health counseling.

(5) Mood Disorders.

(a) Disturbance of mood accompanied by a full or partial manic or depressive syndrome.

(b) Involves either prolonged depression or elation.

(c) Symptoms may exist with or without psychotic features.

(d) An increase or decrease in motor activity is common.

(e) Sleep disturbances may occur such as insomnia, hypersomnia, and feeling no need for sleep.

(f) Recommended treatment and long term management options include hospitalization, psychotropic medications, and supportive psychotherapy.

*NOTE:* Use care to safeguard the depressed client against suicide.

(6) Schizophrenic Disorders.

(a) Disturbance in multiple processes of thought and behavior.

(b) Presence of hallucinations, delusions, or illusions in the active phase of the illness.

(c) Deterioration from a previous level of functioning in areas of occupation, interpersonal relationships, and self-care.

(d) Grossly disorganized thought with bizarre content and loosening of associations.

(e) Gross disorganization of personality.

(f) Onset usually occurs during adolescence or early adulthood, but the disorder may begin in middle or late adult life.

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(g) Duration of symptoms at least 6 months.

(h) Recommended treatment options include medication, individual and group psychotherapy, recreational and occupational activities, and family counseling.

### (7) Paranoid Disorders.

(a) Presence of persistent, nonbizarre delusion that is not due to any other mental disorder.

(b) Behavior is not obviously odd or bizarre.

(c) Auditory or visual hallucinations, if present, are not prominent.

(d) No apparent loss of intellectual or occupational functioning.

(e) Impairment of social and marital functioning is usually present.

(f) Emotions and behavior are usually appropriate to the content of the delusion.

(g) Onset is usually in middle or late adult life.

(h) Rarely seek treatment on their own.

(i) Recommended treatment and management options include required hospitalization for dangerous paranoid clients, chemotherapy, and psychotherapy.

### (8) Adjustment Disorders.

(a) Maladaptive reaction to psychological stressor occurring within 3 months of the stressor and persisting no more than 6 months.

(b) External factors cause sudden, severe or chronic stress.

(c) Impairment in social and occupational functioning.

(d) Symptoms are in excess of a normal and expected reaction to the stressor.

(e) Disturbance will remit soon after the stressor is removed or when a new level of adaptation is achieved.

(f) Stressors and symptoms of stress are often associated with the client's psychosocial stage of development of adolescence, adulthood, and late adulthood.

(g) Recommended treatment and management options include crisis intervention and guidance and extended supportive counseling.

(9) Psychotic Disorders not elsewhere classified.

(a) Maladaptive reactions characterized by impairment in social or occupational functioning that can not be classified as any of the disorders previously discussed.

(b) Symptoms are in excess of a normal and expected reaction to the stressor.

(c) Reaction remits after the stressor ceases or, if the stressor persists, when a new level of adaptation is achieved.

(d) Stressors may be single, multiple, and recurrent.

(e) The severity of a stressor is affected by its duration, timing, and context in a person's life.

(f) Stressors may affect an individual, group, and community.

(g) Severity of reaction is not completely predictable from the severity of the stressor.

(10) Sexual Disorders.

(a) Sexual Dysfunctions.

1) Persistent or recurrent inability to experience the "normal" desires or psychophysiological changes involved in the complete sexual response cycle.

2) Problems in experiencing sexual desires by being constantly preoccupied with sexual urges or absences of them for long period of time.

3) Sexual arousal difficulties while undergoing or maintaining the physical changes in the body and genital organs.

4) Can not control orgasm or have too much control to the extent of not being able to release orgasm.

5) Persistent or recurrent pain during intercourse.

(b) Paraphilia.

1) Arousal in response to sexual objects or situations that are not part of normative arousal activity patterns.

2) Degree of severity may interfere with the capacity for reciprocal affectionate sexual activity.

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3) Recurrent, intense, sexual urges and sexually arousing fantasies involving nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or other nonconsenting persons.

4) Duration is of at least 6 months.

5) Acts on these urges and is markedly distressed by them.

(c) Recommended treatment and management options include referral for medical examination, sex therapy, individual counseling, and sex education.

b. Identify the presence of characteristics of Organic Disorders--mental disorders caused by or associated with impairment of brain function which may be psychotic or nonpsychotic.

(1) The condition may be acute (temporary and reversible) or chronic (permanent and irreversible).

(2) Symptoms are a result of--

(a) Head trauma or injury.

(b) Exposure to toxic substances.

(c) Intoxication with withdrawals from alcohol and other drugs.

(d) Cardiovascular disorder such as a stroke and heart failure.

(e) Systemic medical condition such as the effects of general anesthetics, pneumonia, or typhoid.

(f) Diffuse atrophy of brain tissue.

(g) Intracranial conditions such as tumors, infections, and arteriosclerosis.

(h) Degenerative diseases of the nervous system.

(3) Impairment of recent, remote memory or immediate recall.

(4) Disorientation in time, place, situation, or person.

(5) Changed and impaired level of awareness.

(6) Impaired attention and ability to concentrate.

- (7) Perceptual disturbance.
  - (8) Irritability, labile affect, and anxiety.
  - (9) Impaired judgment.
  - (10) Impaired intellect such as inability to count, subtract, or interpret a familiar proverb.
- c. Identify the presence of the characteristics of V Codes--Conditions not Attributable to Mental Disorders.
- (1) Thorough evaluation has failed to uncover any mental disorders.
  - (2) Diagnostic evaluations may not have been adequate to determine the presence or absence of a mental disorder.
  - (3) There is a need to note the reasons for contact with the mental health system.
  - (4) Conditions may be culturally engendered and may produce severe emotional distress in otherwise psychologically normal people.
- 4. Record impressions and observations.
  - 5. Provide the clinical supervisor with the impressions and observations.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Review collateral information. (See task 081-832-0062.)	P F
2. Interview the client. (See task 081-832-0063.)	P F
3. Assess the client for Psychopathological Disorders.	P F
4. Record impressions and observations.	P F
5. Provide the clinical supervisor with the impressions and observations.	P F

<b>REFERENCES:</b>	<i>Required</i>	<i>Related</i>
	None	AR 635-200

**081-832-0023**

**DETERMINE A CLIENT'S HOMICIDAL POTENTIAL**

**CONDITIONS**

You are conducting an information gathering interview with a client whose presenting problem indicates homicidal tendencies. Necessary materials: client's case file, SF 600, and notepaper.

**STANDARDS**

Make an assessment of the client's potential for homicide and record the information accurately.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Identify behaviors that indicate an increased potential for homicide.
  - a. Verbal--such statements as, "I got so angry I wanted to kill him", or "We'd all be better off without the captain."
  - b. Situational--arguments or ongoing conflicts with spouse, friends, neighbors, or authority figures.
  - c. Psychological.
    - (1) Psychotic symptoms.
      - (a) Delusional jealousy. Client is convinced that spouse or lover is unfaithful with no real evidence.
      - (b) Other delusions. For example, other people are demons and/or that he or she has been chosen to rid the world of evil.
      - (c) Hallucinations. Hearing voices that tell the client to kill someone.
    - (2) Personality traits.
      - (a) Strong feelings of inadequacy or weakness.
      - (b) Strong need to control one's environment.
      - (c) Poor impulse control.
      - (d) Expects gratification without responsibility.

- d. Indicators from childhood history.
    - (1) Absence of role models.
    - (2) Parental aggression or seduction.
    - (3) Firesetting.
    - (4) Bed-wetting.
    - (5) Cruelty to animals.
    - (6) Cruelty to other children.
  - e. Behavioral indicators.
    - (1) Addiction.
    - (2) Excessive use of alcohol.
    - (3) Driving while intoxicated.
    - (4) Sexual acting out.
    - (5) Assault or disorderly conduct.
    - (6) Bizarre behavior.
    - (7) Childish grandiosity.
    - (8) Homicidal fantasies.
  - f. Social and cultural indicators.
    - (1) Cultural belief that one's honor (or the family's honor) must be defended.
    - (2) Cultural values that support use of violence to settle arguments.
    - (3) Absence of membership to institutions that impose controls on the individual's behavior such as the church, school, or family.
2. Question the client about homicidal potential.
- a. Ask the client about homicidal ideation--thoughts of resolving the situation by hurting someone.

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b. Inquire about homicidal plans.

(1) Time.

(2) Place.

(3) Method.

c. Determine if the method is consistent with the available means. For example, if the client says he or she is going to shoot someone, find out if the client has a gun.

3. If the client exhibits homicidal ideation or plans, consult with your supervisor before releasing the client.

4. Record the assessment and the supporting criteria accurately in SF 600.

***Evaluation Guide***

**Performance Measures**

**Results**

*NOTE:* This task may be evaluated at the same time as task 081-832-0063.

- |   |   |   |
|---|---|---|
| 1. Identify behaviors that indicate increased potential for homicide. | P | F |
| 2. Question the client about homicidal potential.                     | P | F |
| 3. Consult with your supervisor before releasing the client.          | P | F |
| 4. Record the assessment and the supporting criteria.                 | P | F |

**REFERENCES:** None

081-832-0026

## DETERMINE A CLIENT'S SUICIDAL POTENTIAL

### CONDITIONS

You are conducting an information gathering interview with a client whose presenting problem or collateral information indicates suicidal behaviors. Necessary materials: client's case file, SF 600, and notepaper.

### STANDARDS

Make an assessment of the client's potential for suicide and record the information accurately.

### TRAINING AND EVALUATION

#### *Training Information Outline*

1. Identify indicators of suicidal potential.
  - a. Verbal.
    - (1) Direct, such as, "I'm going to kill myself."
    - (2) Indirect, such as, "They'll be sorry when I'm gone."
  - b. Behavioral.
    - (1) Direct, such as suicide gesture or attempt.
      - (a) Gesture--any deliberate attempt at self-harm that is nonfatal.
      - (b) Attempt--an act by which the client actually intends to die.
    - (2) Indirect.
      - (a) Writing a will.
      - (b) Giving away prized possessions.
      - (c) Talking about taking a long trip.
      - (d) Increase in alcohol use.
      - (e) Social withdrawal.
      - (f) Lack of concern for others' reaction to the suicidal ideation.

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(g) Taking unusual risks.

(h) Increased antisocial behavior--stealing, child and spouse abuse, truancy from school or work, and irresponsible financial behavior.

c. Physical.

(1) Change of appetite, usually decreased.

(2) Weight loss.

(3) Insomnia or other sleep disturbance.

(4) Decrease in sexual interest or energy.

(5) Frequent complaints of headaches, lower back pain, or indigestion.

d. Psychological.

(1) Deterioration of personal hygiene and appearance.

(2) Agitated behavior or psychomotor retardation.

(3) Feelings of depression.

(a) Helplessness and hopelessness.

(b) Pervasive sense of low self-esteem or worthlessness.

(c) Loss of interest in usually pleasurable activities.

(d) Extreme anger and severe nervousness.

*NOTE:* Occasionally a sudden uplift in spirits indicates the decision to commit suicide. The uplift creates enough energy to carry out the act.

(4) Hallucinations--hearing voices telling the client to kill himself or herself.

(5) Cognitive functioning.

(a) Disorientation or confusion.

(b) Impulsiveness.

(c) Suicidal ideation.

- e. Recent stressors.
  - (1) Rejection by a loved one.
  - (2) Death of a close friend, spouse, or family member.
  - (3) Terminal illness.
  - (4) Disfiguring surgery or accident.
  - (5) Financial loss.
  - (6) Significant career or employment changes.
  - (7) Retirement.
- f. Past history.
  - (1) Failure to maintain productive work.
  - (2) Inability to maintain meaningful interpersonal relations.
  - (3) Suicidal gestures as a means of coping.
  - (4) Suicide or suicidal attempts by a family member or close friend.

*NOTE:* Anniversaries of losses are high risk periods. Inquire into dates of family deaths, retirements, and other significant events.

2. If the client exhibits any clues which indicate an increased potential for suicide, ask the client directly about thoughts of hurting or killing himself or herself.

3. If the client exhibits suicidal ideation, determine whether the client has a suicide plan.

- a. Inquire about--
  - (1) Time.
  - (2) Place.
  - (3) Method.

*NOTE:* The more lethal the method, the greater the risk.

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b. Determine if the method is consistent with the available means. For example, if the client says he or she plans to use a gun, determine if the client has a gun.

*NOTE:* If the client exhibits suicidal behavior, suicidal ideation, or has a suicide plan, do not leave the client unattended.

4. Consult with your supervisor immediately to determine the appropriateness of--

a. Behavioral contract with the client.

(1) If so, encourage the client to sign a written agreement to contact a trusted member of his or her unit, a supervisor, emergency room, or a counselor from your agency prior to attempting a self-destructive act.

(2) Give the client telephone numbers of persons to contact.

b. Further evaluation or hospitalization for the client.

c. Client's return to duty with close supervision/observation.

5. Ensure the client is escorted to the proper location once the appropriate disposition is made.

6. Record the assessment and supporting criteria accurately in SF 600.

*Evaluation Guide*

**Performance Measures**

**Results**

*NOTE:* This task may be evaluated at the same time as task 081-832-0063.

1. Identify indicators of suicidal potential.	P	F
2. Confront the issue of suicide directly.	P	F
3. Determine whether the client has a suicide plan.	P	F
4. Consult with the supervisor before releasing the client.	P	F
5. Ensure the client is properly escorted according to disposition.	P	F
6. Record the assessment and supporting criteria accurately.	P	F

**REFERENCES:** None

081-832-0065

**ASSESS SUBSTANCE USE, ABUSE, OR DEPENDENCY**

**CONDITIONS**

You are conducting an information gathering interview. All collateral information has been obtained. Necessary materials: client's case file, SF 600, and notepaper.

**STANDARDS**

Make an assessment of the client's substance use, abuse, or dependency and record the information accurately.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Assess the client for symptoms of substance abuse.

*NOTE:* The three criteria below must be met in order to diagnose alcohol or other drug abuse.

- a. Pattern of pathological use of alcohol or other drugs manifested by--
  - (1) Intoxication throughout the day.
  - (2) Inability to decrease or stop use.
  - (3) Repeated efforts to control use through periods of temporary abstinence or by restricting use to certain times of the day.
  - (4) Continued use despite knowledge of a serious physical disorder that is aggravated by use of the substance.
  - (5) Need for daily use to function adequately.
  - (6) Complications of substance intoxication such as blackouts.
- b. Impairment of social or occupational functioning due to the pattern of pathological use described in steps 1a(1) through 1a(6).
  - (1) Loss of job or absence from work.
  - (2) Loss of friends.

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(3) Frequent arguments with family members or friends that may result in incidents of violence.

(4) Legal difficulties.

c. Minimum duration of symptoms--1 month.

*NOTE:* Signs of a disturbance need not be continuously present throughout the month, but frequent enough for impairment of functioning to be apparent.

2. Assess the client for symptoms of substance dependence--evidence of tolerance or withdrawal.

a. Tolerance--markedly increased amounts of the substance are required to achieve the desired effect or a markedly diminished effect from regular use of the same dose.

b. Withdrawal--substance specific syndrome follows the cessation or reduction of intake of the substance which was regularly used by the client to induce a state of intoxication.

3. Make appropriate track recommendation for further treatment based on assessment of the client.

*NOTE:* The Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) consists of three tracks.

a. Track I.

(1) Provides drug awareness education and individual or group counseling on an outpatient basis.

(2) Often used with individuals referred for an isolated incident of poor judgment regarding substance use.

(3) Enrollment does not exceed 30 days but includes 12 hours of education, as a minimum.

b. Track II.

(1) Provides individual, group, and family counseling on an outpatient basis.

(2) Enrollment is for a minimum of 30 days but does not exceed 360 days.

c. Track III.

(1) Provides intensive residential (inpatient) rehabilitation treatment.

(2) Duration is 6 to 8 weeks with outpatient follow-up for a total treatment period of 1 year.

(3) Inpatient portion of the treatment is under direct supervision of medical personnel and a medical evaluation is required prior to placement in Track III.

- d. Self-help programs such as Alcoholics Anonymous.
- e. Antabuse--a drug taken orally and daily to deter intake of alcohol.

*NOTE:* When a person on antabuse ingests alcohol, to include small quantities contained in mouthwash or foods, he or she may experience a reaction ranging from flushing, sweating, and palpitation to nausea and vomiting. A physician's order is required to prescribe antabuse.

- 4. Consult with the supervisor regarding your recommendations for disposition or treatment.
- 5. Inform the client of disposition or treatment.
- 6. Complete the referral if the client is to be referred to the ADAPCP or further treatment. (See task 081-832-0007.)
- 7. Record the assessment and the supporting criteria accurately in SF 600.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Assess the client for symptoms of substance abuse.	P	F
2. Assess the client for symptoms of substance dependence.	P	F
3. Recommend further treatment.	P	F
4. Consult with your supervisor.	P	F
5. Inform the client of disposition/treatment.	P	F
6. Complete the referral if necessary.	P	F
7. Record the assessment and the supporting criteria.	P	F

**REFERENCES:**

***Required***

None

***Related***

AR 600-85

**081-832-0007**

**CONDUCT REFERRAL SERVICE FOR INDIVIDUALS**

**CONDITIONS**

You have determined the need to refer a client based on the nature or severity of the problem. Necessary materials: SF 600, telephone directory, and access to a telephone.

**STANDARDS**

Refer the client to the appropriate agency. Document the referral procedure accurately.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Determine the urgency for the referral.

*NOTE:* If it is suspected that the client is psychotic, suicidal, homicidal, or if the situation is life-threatening, seek immediate supervision. (See task 081-832-0013.)

2. Determine the specific type of services needed.

- a. Financial planning or assistance.
- b. Marital or family counseling.
- c. Spiritual or religious assistance.
- d. Educational assistance.
- e. Substance abuse counseling.
- f. Medical services.
- g. Legal services.

3. Identify the agency that is best able to provide the service required.

- a. The Army Continuing Education Program, Army Correspondence Course Program, and the Army Education Centers provide assistance with education and career development.

- b. The Army Community Service provides financial counseling, debt liquidation, consumer education, welcome services which include post information and loaning household items, relocation assistance,

exceptional family member assistance, sole parent assistance, family advocacy, foster care, child care, referral, follow-up assistance, and emergency food locker.

c. The Army Emergency Relief provides emergency loans.

d. The Alcohol and Drug Abuse Prevention and Control Program provides education, prevention, identification, and treatment services.

e. The Army Medical Department, the Uniformed Services Health Benefits Program, and the Civilian Health and Medical Program for the Uniformed Services provide for medical care.

f. The American Red Cross--

(1) Collects information to verify emergency leaves and reports on health, welfare, and whereabouts of family members.

(2) Provides supplementary information for deferments, compassionate reassignments, discharges, and financial assistance.

g. The Community Mental Health Activity provides consultation, outpatient counseling services, diagnosis, and referral.

h. The Social Work Service in an Army hospital provides consultation, discharge planning, and counseling services to inpatients and outpatients, marital and family counseling, crisis intervention, treatment services for family advocacy cases, counseling for unplanned pregnancies and single parents, and referral.

i. The Army finance officer will assist in solving pay problems.

j. The chaplain provides assistance with spiritual and religious needs.

k. The Staff Judge Advocate and the Army Legal Assistance Program provide legal assistance.

*NOTES:* 1. The Inspector General handles complaints or grievances. Always consider whether problems may be solved more quickly and simply by referring them to the soldier's immediate commanding officer. Soldiers should also be referred to their commander when they have questions or problems of an administrative nature.

2. If possible, clients should be referred to a military agency rather than a nonmilitary agency.

4. Explain the recommendation for referral to the client.

a. Agency being referred to.

b. Purpose of the referral.

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- c. Services available from the agency.
5. Ask the client to sign a privacy statement.
6. Contact the selected agency.
  - a. Provide the agency with information about the client on a "need to know" basis, releasing only the information necessary for the agency to provide the services requested.
  - b. Identify the point of contact for the client.
  - c. Identify any special procedures that the client may have to follow to receive service. For example, scheduling appointments, bringing medical records, and completing any special forms.
7. Ensure that the client understands the referral instructions.
  - a. Ask the client to repeat the instructions.
  - b. If the client has any difficulties, write down the instructions.
  - c. Prior to ending the session, encourage the client to follow the instructions.
8. Document the referral recommendation and action taken in the client's case file.
9. Follow up.
  - a. Contact the referral agency.
    - (1) Ask whether the client's appointment was kept.
    - (2) Ask what disposition was made.
  - b. Contact the client.
    - (1) Ask whether his or her needs were met by the services rendered.
    - (2) Ask if other needs or situations exist with which you may be of assistance.
    - (3) If it is your impression that other needs exist which the client is not aware of or is not addressing, discuss the needs openly.
  - c. When all needs have been met, close the client's case file.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Determine the urgency for the referral.	P F
2. Determine the type of service needed.	P F
3. Identify the agency for referral.	P F
4. Explain the recommendations for the referral to the client.	P F
5. Ask the client to sign a privacy statement.	P F
6. Contact the selected agency.	P F
7. Ensure that the client understands the referral instructions.	P F
8. Document the referral recommendation and action taken.	P F
9. Follow up the client's referral.	P F

**REFERENCES:**

*Required*

None

*Related*

AR 20-1  
 AR 27-1  
 AR 27-3  
 AR 40-4  
 AR 600-85  
 AR 608-1  
 AR 608-18  
 AR 621-5  
 AR 930-4  
 AR 930-5  
 DA Pam 351-20  
 DOD Reg 6010.8-R

**081-832-0066**

**CONDUCT A COUNSELING SESSION**

**CONDITIONS**

You have been instructed to provide counseling for a client experiencing situational problems. The client has had a thorough initial evaluation and is able to function in a nonhospital environment. Necessary materials: client case file, collateral records, and notepaper.

**STANDARDS**

Set counseling goals and implement an intervention plan.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Prepare for counseling.
  - a. Gather available information concerning the client.
    - (1) Obtain the client's case record.
    - (2) Talk with the interviewer for any information not written in the case record, if someone else did the initial interview.
    - (3) Obtain any test (MMPI-2, others) not included in the case record.
    - (4) Obtain the client's medical records, if applicable.
  - b. Review the client's case record.
    - (1) Perform any collateral interviews if deemed necessary after viewing the case record.
    - (2) Read the client's case record and note the referral source.
    - (3) Note the type of problem, its onset and duration, and its effect on the client.
    - (4) Note any attempts on the part of client to resolve the situation.
    - (5) Note the "Specialist's Impressions" section.
    - (6) Note any other information helpful in formulating an initial approach.

(7) Information in the case record should not be taken at face value, but used as a starting point. If this is the first counseling session, the information should be reviewed with the client. Look for inconsistencies.

c. Prepare the counseling site.

(1) Locate an appropriate area for counseling. If your own office is not available, borrow an office for the specific time of the counseling session.

(2) Maximize privacy. Use privacy screens if you must use a ward.

(3) Minimize possible distractions by--

(a) Coordinating with the staff to hold your telephone calls.

(b) Notifying the staff to avoid unnecessary interruptions during your session.

(c) Displaying an "interview or counseling session in progress" sign on the door.

(d) Being aware of, preventing, and/or managing any possible environmental or physical interruptions such as noise and room temperature.

(4) Provide for the client's comfort by having facial tissues near the client's chair.

2. Initiate the session.

a. Greet the client.

(1) Walk out to meet the client.

(2) Address the client by rank or title and name.

(3) Introduce yourself including your name, rank, job title, and role.

(4) Escort the client to the counseling area. Ask him or her to be seated.

b. Explain the counseling role.

(1) Explain the purpose of the first session.

(a) Review of the problem(s).

(b) Set counseling goals.

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(2) Explain the relationship of the client and counselor as one in which they work together to find solutions.

(3) Explain counseling rules regarding the limits on privacy and confidentiality of information.

c. Begin each session with a brief summary of what transpired the preceding session and during the interval between sessions.

3. Review and clarify the problem.

a. Ask the client to describe his or her views and feelings regarding the problem.

b. Ask the client to discuss the frequency of the problem and the situation and duration in which it occurs.

c. Ask the client about the effects of the problem on activities of daily living.

(1) Social functioning.

(2) Occupational functioning.

4. Select the appropriate intervention.

a. Crisis intervention.

(1) The problem is a situational crisis of recent onset.

(2) The problem is generalized, affecting many areas of the client's life.

(3) The client's level of discomfort (stress, anxiety, depression) is too high to permit effective coping.

(4) The client's level of adjustment and social functioning before the onset of crisis was good.

b. Guidance counseling.

(1) The problem is situational, specific, and is affecting few areas of the client's life.

(2) The client perceives, and is able to resolve, the problem with minimal counselor intervention.

(3) The client is likely to have no further need for intervention once the presenting problem is resolved.

(4) The client shows at least moderate motivation for resolution.

(5) The client's level of adjustment and social functioning before the onset of the problem was good.

c. Extended supportive counseling.

(1) The client's adjustment problems have generalized to most areas of functioning.

(2) The client does not see actual resolution of the problem as being within his or her control, or resolution is actually not within his or her control.

(3) The client has had the same or similar presenting problems in the past. It can be predicted he or she will be likely to have them in the future, irrespective of the current solution.

(4) The client's level of adjustment and social functioning was only fair prior to the onset of the presenting problem.

5. Set counseling goals.

a. Summarize the problem(s) to be worked on.

b. Obtain the client's concurrence on the summary of the problem area(s).

c. Obtain the client's input on what kind of outcome he or she would like to see as a result of counseling.

d. Formulate goals in concrete behavioral terms. For example, the client attends monthly counseling sessions, keeps appointments, and participates in the counseling process.

*NOTE:* Goals should be flexible. They may be modified or discontinued as new information emerges during the counseling process.

6. Implement the intervention plan.

a. Present the intervention plan.

(1) Crisis intervention.

(a) Encourage the client to understand the crisis and circumstances surrounding him or her.

(b) Allow the client to ventilate feelings.

(c) Help the client to look at the ways he or she is presently dealing with the problem.

(d) Encourage the client to think of new ways of dealing with the crisis.

(e) Provide specific suggestions to be followed by the client.

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(f) Encourage the client to reestablish contact with his or her social support network, if interrupted.

(g) Reinforce the client's successful handling of situations pertinent to the crisis.

(h) Emotionally support unsuccessful attempts at crisis resolution .

(i) Summarize steps taken to resolve the present crisis and ways the client can resolve future crises.

(2) Guidance counseling.

(a) Provide accurate information to the client.

(b) Present objective alternatives to the solutions presented by the client.

(c) Provide reality-based feedback.

(d) Assist the client in setting and resetting goals as needed.

(e) Make referrals to appropriate community resources.

(f) Encourage the client to do as much as possible to resolve his or her own problem.

(3) Extended supportive counseling.

(a) Reinforce appropriate behaviors and discourage maladaptive ones.

(b) Develop a warm, genuine, and empathic relationship while avoiding overdependency.

(4) Review the plan with the client.

(5) Explain the rationale for the plan.

(6) Discuss the client's feelings toward it.

b. Encourage the client's commitment. Obtain a commitment which states the responsibilities of the counselor and the client to all parts of the plan, the extent of personal involvement, and the efforts required.

c. Reinforce the client's successes by recognition and approval.

d. Monitor the client's progress to determine whether the planned intervention is accomplishing its purpose.

7. Terminate the counseling session.
  - a. Briefly summarize the highlights of the session.
  - b. Obtain the client's concurrence on the summary.
  - c. Discuss the actions to be taken by the client prior to the next counseling session.
  - d. Agree on a definite return appointment.
  - e. Assist the client in making a return appointment by providing an appointment slip that indicates the date, time, place, phone number, and your name.
  - f. Escort the client to the appropriate exit.
8. Record notes of the counseling session in the client's case file IAW local SOP.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Prepare for counseling.	P	F
2. Initiate the session.	P	F
3. Review and clarify the problem.	P	F
4. Select the appropriate intervention.	P	F
5. Set counseling goals.	P	F
6. Implement the intervention plan.	P	F
7. Terminate the session.	P	F
8. Record notes of the counseling session.	P	F

**REFERENCES:** None

081-832-0041

**INITIATE FOLLOW-UP ACTION**

**CONDITIONS**

It has been 2 weeks since you terminated counseling with a client. You are instructed to conduct follow-up action. Necessary materials: client case file and access to a telephone.

**STANDARDS**

Contact the client and referral source, if applicable, to determine the client's level of functioning. Record the follow-up information and recommended action.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

1. Receive feedback from the client concerning the level of functioning since termination of counseling.

P F

*NOTE:* Visit the client in person, if possible and agreeable with the client. If a personal visit is not feasible, use the telephone.

- a. Development of new problems.
- b. Coping skills used since termination of counseling.
- c. Benefit of coping skills gained during the counseling.
- d. Need for further counseling.

2. Telephone the referral source, as appropriate, to determine his or her views on how the client is coping with the situation.

P F

*NOTE:* This must be agreed upon by the client unless he or she was a command referral.

- a. If the referral source is the unit commander, contact the commander and inquire as to the client's effectiveness in the unit.
- b. Ask any other referral source about the client's adjustment since termination of counseling.

**Performance Measures**

**Results**

3. Record the results of follow-up action in the objective data section of the progress notes in the client's case file.

P F

4. Make additional appointments with the client as needed.

P F

**REFERENCES:** None

081-833-0076

## APPLY RESTRAINING DEVICES TO PATIENTS

### CONDITIONS

You have identified the patient and explained the procedure. An assistant is available. Necessary materials and equipment: a bed, wrist and ankle restraining devices, ABD pads, padding materials, litters, flexible gauze (kerlix/kling), rifle slings, web belts, elastic bandages, bandoleers, cravats, and sheets.

### STANDARDS

Apply restraining devices to a patient without causing injury to the patient or yourself.

### TRAINING AND EVALUATION

#### *Training Information Outline*

*NOTE:* In a field environment, the need for restraints may be your own decision, especially in the absence of senior medical personnel.

1. Apply wrist and ankle restraints.

*NOTE:* If you apply ankle restraints, also apply wrist restraints.

### **WARNINGS**

1. Do not attempt to apply restraining devices by yourself. Get adequate help.
2. A patient who is depressed or has an altered level of consciousness should be positioned on the stomach with the head turned to the side.
3. Position restraints to avoid causing further injury to a wound or interfering with IV lines, catheters, and tubes.

- a. Adjustable limb holders (cuff and strap).
  - (1) Clean and powder the skin around the wrists and ankles, if possible.
  - (2) Pad the limb with ABD pads or similar material.
  - (3) Position the restraint cuff over the padded limb.
  - (4) Thread the strap through the loop on the cuff. Pull the straps snugly enough to restrict free movement of the limb.

*NOTE:* If two fingers can be comfortably inserted under the cuff, the restraint is snug enough. The patient, however, must not be able to wiggle his or her hand out of the cuff.

- (5) Wrap the strap around the bedframe.
- (6) Lock the buckle and position it facing the outside of the bedframe for quick access.
- (7) Repeat steps 1a(2) through 1a(6) for each limb.

*NOTE:* The keys to the locked restraints must be readily available.

b. Improvised restraints.

- (1) Clean and powder the skin around the wrists and ankles, if possible.
- (2) Pad the limb with any soft cloth such as towels, gauze, cravats, clean handkerchiefs, or clothing.
- (3) Secure the restraining material (gauze or roller bandage) to the limb with a clove hitch.
- (4) Pull the knot to fit the limb snugly.
- (5) Using a bow knot, tie both free ends to the bedframe in a location inaccessible to the patient.
- (6) Repeat steps 1b(2) through 1b(5) for each limb.

2. Apply mitt restraints.

- a. Place the patient's hand in a naturally flexed position.
- b. Place a soft rolled dressing or similar material in the patient's hand and close the hand.
- c. Wrap the entire hand snugly with a flexible gauze bandage (kerlix, kling).
- d. Secure the bandage with tape, not clips.

**CAUTION**

Remove and replace mitts at least every 8 hours. Clean the skin and perform range-of-motion exercises.

3. Apply sheet restraints.

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*NOTE:* This procedure requires the assistance of another person.

a. Litter or stretcher.

- (1) Unfold a sheet. Hold it at opposite corners and fold it lengthwise.
- (2) Twirl the sheet into a tight roll.
- (3) Place the patient on his or her stomach on a litter. Turn the head to the side.

**WARNING**

Check the patient frequently because he or she may suffocate while in the prone position.

- (4) Place the middle of the rolled sheet diagonally across the patient's upper back and one shoulder.
- (5) Bring both ends of the sheet under the litter, cross the ends, and bring the ends up over the other shoulder and upper back. Tie snugly in the middle of the upper back.
- (6) Secure one wrist to the litter, parallel to the thigh, using a wrist restraint.
- (7) Secure the other wrist above the head by attaching it to the nearest litter handle using a wrist restraint.

**CAUTION**

Use litter or stretcher restraints only as a temporary restraint for a patient who is combative or uncontrollable.

b. Bed.

- (1) Fold a sheet in half lengthwise.
- (2) Tuck approximately 2 feet of one end of the sheet under one side of the mattress at the patient's chest level.
- (3) Bring the other end of the sheet over the patient's chest, keeping the sheet over the arms. Tuck the free end of the sheet snugly under the other side of the mattress.
- (4) If further restriction is necessary, apply sheets in the same manner at the level of the patient's abdomen, legs, knees, and ankles.

*NOTE:* Use this method of restraint only for limiting movement. It is not a secure method of restraining a violent patient.

4. Apply field expedient restraints.

*NOTE:* Field expedient restraints should not be used for long periods of time and should be replaced with regular restraining devices as soon as possible.

a. Mixed equipment. Restraints may be improvised from such items as rifle slings, web belts, bandoleers, or cravats.

(1) Restrain the patient's arms and legs tight enough to restrict movement but not so tight as to restrict circulation.

(2) Lay the patient on the ground.

b. Double litters.

(1) Place the patient on his or her stomach on a litter. Turn the head to the side.

(2) Place the patient's hands alongside the thighs and secure them to the litter with wrist restraints.

(3) Place the other litter, carrying side down, on top of the patient.

(4) Bind the litters together with two or more litter straps.

(5) Place the litter strap buckles in a location inaccessible to the patient.

5. Check the patient at least once every half hour for signs of distress and security of restraints.

**WARNING**

The use of restraints has the following hazards:

- Tissue damage under the restraints.
- Development of pressure areas.
- Nerve damage.
- Injury or death in case of fire or other emergencies.
- Inability to effectively resuscitate a patient.
- Possibility of shoulder dislocations in combative patients or those with seizure activity.

6. Change the patient's position at least once every 2 hours, day and night. Exercise the limbs through normal range-of-motion activities.

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7. Evacuate the patient, if necessary.

*Evaluation Guide*

**Performance Measures**

**Results**

- |   |   |   |
|---|---|---|
| 1. Apply wrist and ankle restraints, as applicable. | P | F |
| 2. Apply mitt restraints, as applicable.            | P | F |
| 3. Apply sheet restraints, as applicable.           | P | F |
| 4. Apply field expedient restraints, as applicable. | P | F |
| 5. Check the patient.                               | P | F |
| 6. Change the patient's position.                   | P | F |
| 7. Evacuate the patient, if necessary.              | P | F |
| 8. Do not cause further injury to the patient.      | P | F |

**REFERENCES:** None

081-833-0103

**PROVIDE CARE FOR A SOLDIER WITH SYMPTOMS OF BATTLE FATIGUE**

**CONDITIONS**

A soldier in a combat environment displays signs and symptoms of battle fatigue.

**STANDARDS**

Classify the degree of battle fatigue and treat the soldier accordingly.

**TRAINING AND EVALUATION**

*Training Information Outline*

*NOTE:* Battle fatigue refers to combat stress symptoms and reactions which may manifest as emotional and/or physical conditions. The soldier's mission performance may not be affected. Battle fatigue is considered a "normal" condition which could occur in anyone subjected to the physical and emotional stress of combat.

1. Identify contributing causes of battle fatigue.

*NOTE:* These are factors that have been historically identified as contributors to increasing battle fatigue rates.

- a. Sudden exposure to the intense fear, stimuli, and life/death consequences of battle.
- b. Cumulative exposure to dangers, responsibilities, and consequences of combat, including repeated grief and guilt over loss of comrades, friends, or patients.

*NOTE:* This may lead to the sense that one's own luck, skill, and courage have been used up.

- c. Physical stressors.
  - (1) Sleep loss.
  - (2) Lack of food and/or water.
  - (3) Physical exhaustion or excessive physical demands.
  - (4) Inclement weather.
  - (5) Lack of facilities for personal hygiene.

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- (6) Environmental illnesses.
- (7) Cumulative exposure to combat conditions (noise, odor, discomfort).
- d. Psychosocial factors.
  - (1) Worry about family members and friends.
  - (2) Homefront worries (debts, "Dear John" letters, family illness/death).
  - (3) Lack of confidence in oneself, leaders, comrades, and/or equipment.
- 2. Check the casualty for signs and symptoms of battle fatigue.
  - a. Simple fatigue.
    - (1) Loss of initiative.
    - (2) Tiredness.
    - (3) Indecisiveness.
    - (4) Inattention.
  - b. Anxiety.
    - (1) Marked startle response.
    - (2) Tremors.
    - (3) Sweating.
    - (4) Insomnia with terror dreams.
    - (5) Rapid heartbeat.
  - c. Depression.
    - (1) Self-doubt.
    - (2) Self-blame.
    - (3) Hopelessness.
    - (4) Grief.

- (5) Bereavement.
- d. Memory loss.
  - (1) Ranges from inability to remember recent instruction to loss of memory of well learned skills.
  - (2) Loss of memory of a traumatic event or period of time.
  - (3) Total amnesia or fugue state (soldier leaves his post, forgets his own past, goes somewhere else, and may assume a new identity).
- e. Physical function disturbance.

*NOTE:* These symptoms are not due to a physical cause and may have a clear symbolic relationship to a specific trauma or conflict of motivation.

- (1) Motor functions.
  - (a) Weakness or paralysis of hands, limbs, or body.
  - (b) Gross tremors.
  - (c) Sustained contractions of muscles.
- (2) Sensory functions.
  - (a) Visual symptoms--tunnel vision or total blindness.
  - (b) Auditory symptoms- -dizziness, ringing in the ears, or deafness.
  - (c) Tactile changes--loss of sensations or abnormal sensations.
  - (d) Speech--stuttering, hoarseness, or muteness.

3. Classify battle fatigue cases.

*NOTE:* Classification labels are based on where the soldiers can be treated and therefore, depend as much on the situation of the unit as on the symptoms of the soldier. The classification has only transient significance due to the quickly changing nature of the battle fatigue symptoms.

- a. Duty--can be treated within the small unit while remaining on duty status.
- b. Rest--treated in a nonmedical support unit on a limited duty status for 1 to 2 days.

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c. Hold--requires holding for restorative treatment in the medical unit where the soldier is being evaluated.

d. Refer--requires transfer to the next echelon medical facility for further evaluation.

4. Use basic treatment principles for battle fatigue.

*NOTE:* The acronym "PIES" is a method of remembering how to treat soldiers with battle fatigue.

a. Proximity--treat as close to the soldier's unit and the battle as possible to reduce overevacuation.

b. Immediacy--treat immediately, without delay.

c. Expectancy--express positive expectation of a full, rapid recovery.

d. Simplicity--use simple, brief methods to restore physical well-being and self-confidence, and use nonmedical terminology and techniques with the soldier.

5. Perform appropriate treatment interventions for battle fatigue.

a. Maintain a military atmosphere.

(1) Have the soldier dress in a field uniform.

(2) Have the soldier maintain his or her field equipment.

(3) Keep the soldier busy with physical exercise, useful work details, and military training.

(4) Maintain appropriate military rank distinctions and courtesies.

b. Encourage the soldier to--

(1) Sleep or rest.

(2) Eat and drink to replenish lost fluids.

(3) Shower and clean up, if possible.

c. Reassure the soldier that other soldiers have had the same experience and symptoms and have recovered and returned to duty.

d. Encourage the soldier to talk about what has happened and about his or her emotions and unacceptable feelings.

(1) Maintain an accepting attitude.

- (2) Assist the soldier in finding a more adaptive perspective to what has happened.
- (3) Focus on lessons learned and alternative methods of coping.
- e. Recognize that some physical or mental illnesses may resemble battle fatigue.
  - (1) Hypothermia.
  - (2) Blunt trauma injury.
  - (3) Substance abuse.
  - (4) Laser eye injury.
  - (5) Nerve agent or atropine poisoning.
  - (6) Psychiatric and personality disorders.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Identify contributing causes of battle fatigue.	P F
2. Check the soldier for signs and symptoms of battle fatigue.	P F
3. Classify the battle fatigue case.	P F
4. Use basic treatment principles for battle fatigue.	P F
5. Perform appropriate treatment interventions for battle fatigue.	P F

**REFERENCES:** None

**PREPARE AN INJECTION FOR ADMINISTRATION**

**CONDITIONS**

You have performed a patient care handwash. Necessary materials and equipment: needles and syringes, medication, alcohol sponges, dry sterile gauze, and physician's orders.

**STANDARDS**

Select, inspect, and assemble the appropriate needle and syringe. Draw the correct medication. Follow aseptic technique throughout the procedure.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Select an appropriate needle.
  - a. Select a needle with the proper length based upon the following factors:
    - (1) The type of injection to be given (subcutaneous, intramuscular, or intradermal).
    - (2) The size of the patient (thin, obese).
    - (3) The injection site (1 inch for deltoid, 1 1/2 inches for gluteus maximus).
  - b. Select a needle with the proper gauge based upon the thickness of the medication to be injected.

*NOTE:* The gauge of the needle is indicated by the numbers 14 through 27. The higher the number, the smaller the diameter (bore) of the needle. A small bore needle is indicated for thin medications. A large bore needle is indicated for thick medications.

2. Select an appropriate syringe.
  - a. Check the drug manufacturer's specifications to determine whether a glass or plastic syringe should be used for the medication.

*NOTE:* Some medications deteriorate in a plastic syringe. Drug manufacturer's specifications provide guidance.

- b. Ensure that the total capacity of the syringe, usually measured in cubic centimeters (cc), is appropriate for the amount of medication to be administered.

- c. Check the intervals of the calibration marks on the syringe.
3. Inspect the needle and syringe packaging for defects such as open packages, holes, and water spotting. Discard the equipment if any defect is found.
  4. Unpack the syringe.
    - a. If the syringe is in a flexible wrapper, peel the sides of the wrapper apart to expose the rear end of the syringe barrel.
    - b. Grasp the syringe by the barrel with the free hand.

**CAUTION**

The needle adapter and the shaft of the plunger are sterile. Contamination could cause infection in the patient. The outside of the syringe barrel does not have to be kept sterile.

- c. Pull the syringe from the packaging.
  - d. If the syringe is packaged in a hard plastic tube container, press down and twist the cap until a distinct "pop" is heard. If the "pop" is not heard, the seal has been previously broken and the equipment must be discarded.
5. Inspect the syringe.
    - a. Grasp the flared end of the syringe and pull the plunger back and forth to test for smooth, easy movement.
    - b. Visually check the rubber stopper (inside the syringe) to ensure that it is attached securely to the top end of the plunger, forming a seal.
    - c. If the plunger is stuck or does not move smoothly, discard the syringe.
    - d. Push the plunger fully into the barrel until ready to fill the syringe with medication.
  6. Unpack the needle.

**CAUTION**

All parts of the needle are sterile. Be careful not to touch the hub. This would contaminate the needle and possibly pass an infection to the patient. Only the outside of the needle cover may be touched.

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- a. If the needle is packaged in a flexible wrapper, peel the sides of the wrapper apart to expose the needle hub.
- b. If the needle is packaged in a hard plastic tube, twist the cap of the tube until a "pop" is heard. Remove the cap to expose the needle hub. If a "pop" is not heard, the seal has been previously broken, and the equipment must be discarded.

### 7. Join the needle and the syringe.

- a. Insert the needle adapter of the syringe into the hub of the needle.
- b. Tighten the needle by turning 1/4 of a turn to ensure that it is securely attached.

### 8. Inspect the needle.

- a. Hold the needle and syringe upright and remove the protective cover from the needle by pulling it straight off.

*NOTE:* A twisting motion may pull the needle off the hub.

- b. Visually inspect the needle for burrs, barbs, damage, and contamination. If the needle has any defects or damage, replace it with another sterile needle.
- c. Place the protective cover back on the needle.

### 9. Place the assembled needle and syringe on the work surface.

- a. Leave the protective cover on the needle.
- b. Leave the plunger pushed fully into the barrel.
- c. Keep the assembled needle and syringe continually within range of vision.

*NOTE:* When you assemble a needle and syringe, you are responsible for maintaining sterility and security of the equipment.

### 10. Verify the drug label and check the container for defects.

- a. Compare the medication with the doctor's orders. The medication label must be verified three times.
  - (1) When obtained from the place of storage.
  - (2) When withdrawing the medication.

- (3) When returning the container to storage.
- b. Examine the container.
  - (1) Examine the rubber stopper for defects, such as small cores or plugs torn from the stopper.
  - (2) Hold the vial to the light to check for foreign particles and changes in color and consistency. If the solution is in a dark vial, withdraw some solution to perform the checks.
  - (3) Check the date a multidose vial was opened and check the expiration date of the medication.
  - (4) Determine whether the medication was stored properly, such as under refrigeration.

*NOTE:* If there is any evidence of contamination, discard the container and obtain another.

11. Prepare and draw the medication.

- a. Draw medication from a stoppered vial which contains a prepared solution.
  - (1) Remove the protective cap.
  - (2) Clean the stopper and neck of the vial with an alcohol sponge.
  - (3) Pick up the assembled needle and syringe and remove the protective needle cover.
  - (4) Slowly draw the plunger to the prescribed cc mark of medication.
  - (5) Pick up the vial and insert the needle into the rubber stopper, exerting slight downward and forward pressure. Ensure that the needle tip passes completely through the cap.

*NOTE:* To avoid contamination, the hub of the needle should not touch the rubber cap.

- (6) Push the plunger fully into the barrel to inject the air.
- (7) With the vial inverted (and keeping the needle tip in the solution), pull the plunger back to the desired cc mark, withdrawing the medication.
- (8) Withdraw the needle from the container.
- (9) Verify the correct dosage against the doctor's orders by raising the syringe to eye level and ensuring that the forward edge of the plunger is exactly on the prescribed cc mark.

- b. Draw medication from a stoppered vial which contains a powdered medication which must be prepared.

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(1) Remove the protective caps from the vial containing the powdered medication and the vial containing the sterile diluent.

(2) Clean the stoppers of both vials with alcohol sponges.

(3) Withdraw the required diluent, using the same procedure as for a stoppered vial. (See steps 11a(3) through 11a(8).)

(4) Hold the vial with the powdered medication horizontally, insert the needle through the stopper, and inject the diluent.

*NOTE:* If the vial with powdered medication contains air, the diluent may be difficult to inject. Air may have to be withdrawn to allow the diluent to be injected.

(5) Withdraw the needle.

(6) Gently invert the vial several times until all the powder is dissolved. Visually inspect the solution to ensure that it is well-mixed.

(7) Change the needle (or needle and syringe) and insert it into the vial of reconstituted solution.

(8) Withdraw the prescribed amount of medication. (See step 11a(7).)

(9) Withdraw the needle from the container.

(10) Verify the correct dosage. (See step 11a(9).)

c. Draw medication from an ampule.

(1) Lightly tap the upright ampule to force any trapped medication from the ampule neck and top.

(2) Clean the neck of the ampule with an alcohol sponge and wrap it with the same sponge.

(3) Grasp the ampule with both hands and snap the neck by bending it away from the breakline, directing it away from yourself and others.

(4) Inspect the ampule for minute glass particles. If any are found, discard the ampule.

(5) Remove the protective cover from the assembled needle and syringe.

(6) Insert the needle and withdraw the medication by holding the ampule vertically or by placing the ampule upright on a flat surface.

(7) Withdraw the prescribed medication, being careful not to touch the outside edge or bottom of the ampule with the needle.

- (8) Withdraw the needle and verify the correct dosage. (See step 11a(9).)
- 12. Check the syringe for air bubbles.
  - a. Hold the syringe with the needle pointing up.
  - b. Pull back on the plunger slightly to clear all the medication from the needle shaft.
  - c. Tap the barrel lightly to force bubbles to the top of the barrel.
  - d. Pull the plunger back slightly and push it forward until the solution is in the needle hub, clearing it of bubbles.
- 13. Reverify the correct dosage. (See step 11a(9).)
- 14. Cover the needle with the protective needle cover.

***Evaluation Preparation***

*Setup:* If the performance of this task must be simulated for training and evaluation, colored solutions may be used to simulate medications. Have several sizes of needles and syringes available. Tell the soldier what type of medication is being simulated and what the route of administration would be. Have him or her select the appropriate needle and syringe. To test step 2, tell the soldier of any manufacturer's specifications. Testing may be varied by using various medications to be administered by different routes. Needles and syringes may be reused.

*Brief soldier:* Tell the soldier to assemble the proper needle and syringe and draw the medication.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Select the appropriate needle.	P	F
2. Select the appropriate syringe.	P	F
3. Inspect the packaging for defects.	P	F
4. Unpack the syringe.	P	F
5. Inspect the syringe.	P	F

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- |  |   |   |
|--|---|---|
| 6. Unpack the needle.  | P | F |
| 7. Join the needle and syringe.                                | P | F |
| 8. Inspect the needle.   | P | F |
| 9. Place the assembled needle and syringe on the work surface. | P | F |
| 10. Verify the drug label and check the container for defects. | P | F |
| 11. Prepare and draw the medication.                           | P | F |
| 12. Check the syringe for air bubbles.                         | P | F |
| 13. Reverify the correct dosage.                               | P | F |
| 14. Cover the needle with the protective needle cover.         | P | F |
| 15. Do not violate aseptic technique.                          | P | F |

**REFERENCES:** None

081-833-0089

**ADMINISTER AN INJECTION (INTRAMUSCULAR, SUBCUTANEOUS, INTRADERMAL)**

**CONDITIONS**

You have performed a patient care handwash and have verified the physician's orders. Necessary materials and equipment: syringe(s) with the prepared medication(s), antiseptic pads, alcohol sponge swabs, sterile gauze, adhesive tape, and the patient's record.

**STANDARDS**

Administer the injection IAW the physician's orders without violating aseptic technique or causing injury to the patient.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Verify the required injection(s) with the physician's orders.
2. Identify the patient by asking the patient's name and checking the identification tag or band. Ask the patient if he or she has any allergies or has experienced a drug reaction.

**WARNINGS**

1. If there is a known allergy, do not administer the injection. Consult your supervisor.
2. Determine if a female patient is pregnant because of possible side effects of certain immunizing agents on the unborn child. If there is a question, do not administer the injection without written authorization.

3. Verify that the appropriate needle, syringe, and medication are being used. (See task 081-833-0088.)

*NOTE:* Strict aseptic technique must be employed whenever foreign bodies (the needle and medications) are introduced into body tissues.

**WARNING**

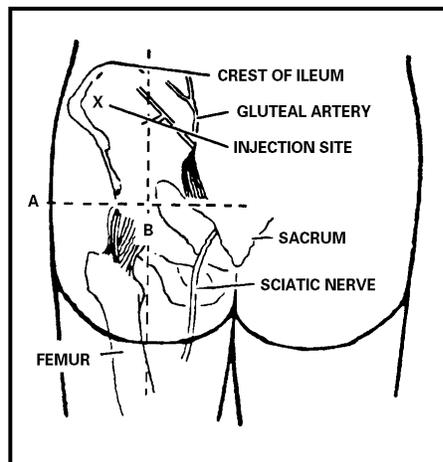
Have an emergency tray available for the immediate treatment of serious reactions. Include a constricting band and a syringe containing a 1:1000 solution of epinephrine. Have a tracheostomy set available since the majority of fatalities reported involve asphyxiation due to laryngeal edema.

4. Select and expose the injection site.
  - a. Intramuscular injection.
    - (1) The upper arm deltoid muscle--the outer 1/3 of the arm between the lower edge of the shoulder bone and the armpit. Approximately three fingerwidths below the shoulder bone is the safe area.
    - (2) Buttocks--the upper-outer quadrant of either buttock.

**WARNING**

Do not give the injection in an area outside the upper-outer quadrant. The needle may do irreparable damage to the sciatic nerve or pierce the gluteal artery and cause significant bleeding.

*NOTE:* To identify the injection site, draw an imaginary horizontal line across the buttocks from hip bone to hip bone. Then divide each buttock in half with an imaginary vertical line. (See Figure 3-2.)



**Figure 3-2**

(3) Outer thigh--the area between a hand's width above the knee and a hand's width below the groin.

b. Subcutaneous injection.

(1) Upper arm.

(2) Outer thigh.

(3) Abdomen.

c. Intradermal injection.

(1) Inner forearm.

(2) Back of the upper arm.

(3) On the back below the shoulder blades.

5. Position the patient.

a. Intramuscular.

(1) Upper arm--standing or sitting with the area completely exposed, muscles relaxed, and the arm at the side.

(2) Buttocks--lying face down or leaning forward and supported by a stable object with the weight shifted to the leg that will not be injected. The area is completely exposed.

*NOTE:* If the patient is lying in a prone position (face down), place the toes together with the heels apart. This will relax the muscles of the buttocks.

(3) Outer thigh--lying face up or seated with the area completely exposed.

b. Subcutaneous.

(1) Upper arm--see step 5a(1).

(2) Outer thigh--lying face up or seated, with the area completely exposed.

c. Intradermal.

(1) Inner forearm--standing, sitting, or lying. Palm up, with the arm supported and relaxed.

(2) Upper arm--see step 5a(1).

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- (3) Back--seated, leaning forward and supported on a stable object, or lying face down.
6. Clean the injection site.
  - a. Intramuscular and subcutaneous.
    - (1) Open the antiseptic pad package.
    - (2) Begin at the injection site and with a spiral motion, clean outward 3 inches.
  - b. Intradermal.
    - (1) Use ethyl alcohol or acetone germicide and a sterile sponge.
    - (2) Begin at the injection site and with a spiral motion, clean outward 3 inches.

*NOTE:* The antiseptic pad may be held between the last two fingers for use when the needle is removed.

7. Pull the needle cover straight off without bending or touching the needle.
8. Prepare the skin for the injection.
  - a. Intramuscular and subcutaneous. Form a fold of skin at the injection site by pinching the skin gently between the thumb and the index finger of the nondominant hand. Do not touch the injection site.
  - b. Intradermal. Using the thumb of the nondominant hand, apply downward pressure directly below and outside the prepared injection site. Hold the skin taut until the needle has been inserted.

**CAUTION**

Do not retract or move the skin laterally.

9. Insert the needle.
  - a. Intramuscular. With the dominant hand, position the needle, bevel up, at a 90 degree angle to, and about 1/2 inch from, the skin surface. Plunge the needle firmly and quickly straight into the muscle to the depth of the needle.
  - b. Subcutaneous. With the dominant hand, position the needle, bevel up, at a 45 degree angle to the skin surface. Plunge the needle firmly and quickly into the fatty tissue below the skin to the depth of the needle.

c. Intradermal. With the dominant hand, position the needle, bevel up, at a 15 to 20 degree angle to the skin surface. Insert it just under the skin until the bevel is covered. Do not move the skin.

10. Release the hold on the skin.

11. Administer the medication.

a. Intramuscular and subcutaneous.

(1) Aspirate by pulling back slightly on the plunger of the syringe.

(a) If blood appears, stop the procedure. Go to step 3 and begin the procedure again. Use a new needle, syringe, and medication, and select a different injection site.

(b) If no blood appears, continue the procedure.

**WARNING**

Failure to aspirate could cause the medication to be injected into the blood stream.

(2) Using a slow continuous movement, completely depress the plunger, injecting the medication.

*NOTE:* Rapid pressure may cause a burning pain.

(3) Place an antiseptic pad (or sterile 2 x 2) lightly over the injection site and withdraw the needle at the same angle at which it was inserted. Gently massage the injection site with the pad, unless this is contraindicated for the medication that has been injected.

(4) Put an adhesive bandage strip over the injection site if bleeding occurs.

b. Intradermal.

*NOTE:* Do not aspirate.

(1) Push the plunger slowly forward until all medication has been injected and a wheal appears at the site of the injection.

(a) If no wheal appears, go to step 3 and begin the procedure again. Use a new needle, syringe, and medication and select a different injection site.

(b) If a wheal appears, continue the procedure.

(2) Quickly withdraw the needle at the same angle at which it was inserted.

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- (3) Without applying pressure, cover the injection site with dry sterile gauze.
  - (4) Instruct the patient not to scratch, rub, or wash the injection site.
  - (5) If appropriate, instruct the patient when and where to have the test read IAW local SOP.
12. Check the site for bleeding.
13. Observe the patient for anaphylactic shock symptoms IAW local SOP. (See task 081-833-0031.)
14. Dispose of the needle and syringe IAW local SOP.
15. Record the procedure on the appropriate form.

***Evaluation Preparation***

*Setup:* If the performance of this task must be simulated for training and evaluation, have another soldier act as the patient. If so, ensure that the prepared syringes contain no more than 0.2 cc of a safe, sterile, injectable solution. Tell the soldier which type of injection to give. Ensure that medical coverage is available in case of reaction.

*Brief soldier:* Tell the soldier to administer the injection.

***WARNING***

If the soldier violates aseptic technique or starts to do something which could injure the patient, stop the evaluation immediately.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Verify the required injection(s) with the physician's orders.	P	F
2. Identify the patient and ask the patient about allergies or drug reactions.	P	F
3. Verify the appropriate needle, syringe, and medication.	P	F
4. Select and expose the injection site.	P	F
5. Position the patient.	P	F

<b>Performance Measures</b>	<b>Results</b>	
6. Clean the injection site.	P	F
7. Remove the needle cover.	P	F
8. Prepare the skin for injection.	P	F
9. Insert the needle.	P	F
10. Release the skin.	P	F
11. Administer the medication.	P	F
12. Check the site for bleeding.	P	F
13. Observe the patient for adverse reactions.	P	F
14. Dispose of the needle and syringe.	P	F
15. Record the procedure on the appropriate form.	P	F
16. Do not violate aseptic technique.	P	F
17. Do not cause further injury to the patient.	P	F

**REFERENCES:** None

**ADMINISTER THE MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-2 (MMPI-2)**

**CONDITIONS**

You are in a clinical setting under the supervision of a psychologist. Necessary materials and equipment: MMPI-2 Manual for Administration and Scoring, test booklet, answer sheet, scoring keys, profile sheet, dictionary, and a testing area with a desk or table and a chair.

**STANDARDS**

Administer, score, and profile the MMPI-2 IAW standard procedures.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Prepare for the test.
  - a. Gather the test booklet, answer sheet, and pencils.
  - b. Ensure the testing area is--
    - (1) Well lighted.
    - (2) Well ventilated.
    - (3) Free from distractions.
    - (4) As comfortable as possible.
2. Greet the client.
  - a. Address the client using the client's appropriate rank.
  - b. Introduce yourself using your rank and last name.
  - c. Seat the client behind the desk or table.
3. Explain the purpose of the test.
  - a. Be truthful.
  - b. Use general but positively stated reasons.

4. Tell the client who will provide feedback on the results of the test.
5. Prepare the answer sheet.
  - a. Ask the client to fill in the appropriate identification data.
  - b. Place the answer sheet on the metal buttons of the test booklet.
  - c. Place the answer sheet and test booklet in front of the client.
6. Tell the client to read the instructions silently while you read them aloud.
  - a. Ask the client if there are any questions regarding the instructions.

*NOTE:* Repeat the instructions as needed.

- b. Tell the client to begin.
    - c. Watch the client complete the first few items to ensure the numbers on the answer sheet line up with the numbers in the test booklet.
7. Answer questions and objections posed by the client during the test.
  - a. Allow the client to use the dictionary to determine the definition of a word.
  - b. Encourage the client to mark all of the items. If the client has difficulty deciding how to mark one or more items, use a general statement such as, "Do not leave a blank space unless you really cannot decide how to mark the item."
  - c. If the client requests guidance on how to respond, tell the client that the answer should reflect his or her own feelings or opinions.
  - d. If the client questions the need for taking the test, restate the purpose of the test, encourage the client to continue, and assure the client that the test will be used for his or her benefit.

*NOTE:* Consult with the supervisor immediately if the client's behavior raises questions on how or if testing should continue.

- e. Answer factual and procedural questions directly.
  - f. Tell the client to answer the questions according to his or her current feelings towards a particular subject instead of some earlier feeling.

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*NOTE:* The client may have experienced a traumatic incident, such as the death of a family member. The client should be encouraged to respond how he or she currently feels regarding the incident, not how he or she felt when the incident occurred.

g. If the client has questions about how he or she should answer items that are only true some of the time, tell the client to answer the item as it generally applies to him or her. For example, if it is false most of the time, then the client should be encouraged to answer false.

8. Terminate testing when the client states that he or she is through.

- a. Check the client's answer sheet for completeness of answers and identification data.
- b. Encourage the client to go back and answer every question if there are many omissions.

*NOTE:* More than 30 omissions may invalidate the test .

- c. Collect all test materials.
- d. Check the test booklet for missing pages and pencil marks.
- e. Terminate the testing session and release the client.

*NOTE:* Release the client to his or her duty section if the client is active duty.

9. Record any significant behavior, questions, or statements made by the client during the testing session.

10. Examine the answer sheet.

- a. Draw a solid line through the T and F circles for unanswered or double answered items.
- b. Look for obvious patterns such as all T's or all F's or repeated sequences.

*NOTE:* Such patterns indicate that the client did not take the test seriously or may not have read the questions.

11. Score the MMPI-2.

a. Count the unanswered and double answered questions and record the number counted as the "?" score.

*NOTE:* The unanswered and double answered questions are not to be used on any other scales.

- b. Place the L scale scoring key over the answer sheet.

(1) Line up the black bars on the bottom of the scoring key with the black bars on the bottom of the answer sheet.

(2) Follow the line on the scoring key and count every mark showing through the squares on the key.

(3) Record the number of marks counted as the raw score for the L scale.

c. Repeat steps 11b(1) and 11b(2) to score the following six scales:

(1) F scale.

(2) K scale.

(3) Hs (1) scale.

(4) D (2) scale.

(5) Hy (3) scale.

(6) Pd (4) scale.

(7) Record the number of marks counted for each scale as the raw score.

d. Score the Mf (5) scale.

(1) Select the scoring key to match the sex of the client.

(2) Repeat steps 11b(1) and 11b(2).

(3) Record the number of marks counted as the raw score for the Mf (5) scale.

e. Repeat steps 11d(1) and 11d(2) to score the following five scales:

(1) Pa (6) scale.

(2) Pt (7) scale.

(3) Sc (8) scale.

(4) Ma (9) scale.

(5) Si (0) scale.

(6) Record the number of marks counted for each scale as the raw score.

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f. Determine which side of the profile sheet is needed according to the sex of the client and make a large "X" on the side not used. (See Figure 3-3.)

g. Write the raw score for each of the scales at the bottom of the profile sheet on the appropriate line.

*NOTE:* One side is for males and the other side is for females.

12. Fill out the client's identification data at the top of the profile sheet.

T or Tc	L	F	K	Hs+.5K 1	D 2	Hy 3	Pd+.4K 4	Mf 5	Pa 6	Pt+1K 7	Sc+1K 8	Ma+.2K 9	SI 0	T or Tc
120	<b>MALE</b>				55	50			30	60				120
115		25					50				65			115
110				40	50					55		40		110
105						45		55			60			105
100	15			35	45				25					100
95		20						50		50	55			95
90				30	40		40					35		90
85						35		45	20	45	50			85
80		15	30	25							45		65	80
75	10						35	40		40		30	50	75
70			25		30	30					40		45	70
65		10		20			30	35	15	35			40	65
60			20		25						35			60
55	5			15		25		30		30		25	35	55
50		5			20		25						30	50
45			15			20		25	10	25	25	20	25	45
40				10	15		20							40
35	0	0				15		20		20	20	15	15	35
30				5	10	10			5	15	15	10	10	30

Raw Score \_\_\_\_\_

?Raw Score \_\_\_\_\_ K to be Added \_\_\_\_\_

Raw Score with K \_\_\_\_\_

**Figure 3-3**

13. Make the K corrections.

- a. Locate the Fractions of K chart on the profile sheet. (See Figure 3-4.)

*NOTE:* The "Fractions of K" chart was removed from the profile sheet for clarity purposes.

Fractions of K			
K	.5	.4	.2
30	15	12	6
29	15	12	6
28	14	11	6
27	14	11	5
26	13	10	5
25	13	10	5
24	12	10	5
23	12	9	5
22	11	9	4
21	11	8	4
20	10	8	4
19	10	8	4
18	9	7	4
17	9	7	3
16	8	6	3
15	8	6	3
14	7	6	3
13	7	5	3
12	6	5	2
11	6	4	2
10	5	4	2
9	5	4	2
8	4	3	2
7	4	3	1
6	3	2	1
5	3	2	1
4	2	2	1
3	2	1	1
2	1	1	0
1	1	0	0
0	0	0	0

Figure 3-4

- b. Find the number in the left-hand column of the Fractions of K chart which corresponds to the raw score of K.

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- c. Draw a line through the Fractions of K, underlining the appropriate raw K score.
- d. Find the number which corresponds to .5K in the Fractions of K chart. Record this number below the raw score for HS (1) scale.
- e. Find the number which corresponds to .4K in the Fractions of K chart. Record this number below the raw score for Pd (4) scale.
- f. Write the raw "K" score below the raw score for Pt (7) scale.
- g. Write the raw "K" score below the raw score for Sc (8) scale.
- h. Find the number which corresponds to .2K in the Fractions of K chart. Record this number below the raw score for Ma (9) scale.
- i. Add the raw scores and K corrections for scales 1, 4, 7, 8, and 9.
- j. Record the sum on the bottom line for each scale.

14. Profile the scores.

- a. Place a dot on the profile sheet to represent the scores for scales L, F, and K.

*NOTE:* These are the validity scales.

- b. Draw a line connecting the three dots.
- c. Place a dot on the profile sheet to represent the scores for scales 1 through 0.

*NOTE:* These are the clinical scales.

- (1) Use the "K" corrected scores for scales 1, 4, 7, 8, and 9.
- (2) Invert the score for the Mf (5) scale if the client is a female -- the higher the score the lower the dot.
- d. Draw a line connecting the dots which represent scales 1 through 0.

*NOTE:* Do not connect the validity scales to the clinical scales when drawing the line.

15. Give the answer sheet, the profile sheet, and any recorded observations to the psychologist.

<b>Performance Measures</b>	<b>Results</b>
1. Prepare for the test.	P F
2. Greet the client.	P F
3. Explain the purpose of the test.	P F
4. Tell the client who will provide feedback on the results of the test.	P F
5. Prepare the answer sheet.	P F
6. Tell the client to read the instructions silently while you read them aloud.	P F
7. Answer questions and objections posed by the client.	P F
8. Terminate testing when the client states that he or she is through.	P F
9. Record any significant behavior, questions, or statements made by the client during the testing session.	P F
10. Examine the answer sheet.	P F
11. Score the MMPI-2.	P F
12. Fill out the client's identification data.	P F
13. Make the K corrections.	P F
14. Profile the scores.	P F
15. Provide testing results to the psychologist.	P F

<b>REFERENCES:</b>	<i>Required</i>	<i>Related</i>
	MMPI-2 Manual	None

**ADMINISTER THE WECHSLER ADULT INTELLIGENCE SCALE-REVISED (WAIS-R)**

**CONDITIONS**

You are in a clinical setting under the supervision of a psychologist. Necessary materials: a complete WAIS-R kit to include the WAIS-R manual, stopwatch, pencils without erasers, notepad, clipboard, and a desk or table with chair.

**STANDARDS**

Administer and score the WAIS-R IAW standard procedures.

**TRAINING AND EVALUATION**

*Training Information Outline*

*NOTES:* 1. In clinical practice, the WAIS-R is an important tool of diagnostic evaluation. The standardized procedure for administering the WAIS-R must strictly follow the manual in order to obtain meaningful results.

2. The WAIS-R is an objective test administered individually to clients who are 16 or older. The WAIS-R compares each individual's performance with the average scores obtained by members of the same age group, measures overall competency and cognitive abilities, and includes nonintellective components such as anxiety, persistence, goal awareness, environment, and heredity.

1. Prepare for the test.
  - a. Gather the test kit and manual.
  - b. Check the test kit for completeness. Materials should include the following:
    - (1) WAIS-R Manual.
    - (2) Spiral bound booklet containing Picture Completion and Block Design items.
    - (3) Spiral bound booklet containing cards for Picture Arrangement items, each item in a separate packet.
    - (4) Cards printed with vocabulary words.
    - (5) Box containing nine red and white blocks for Block Design.
    - (6) Four boxes containing parts for Object Assembly.

- (7) Object Assembly Layout Shield.
  - (8) Scoring stencil for Digit Symbol.
  - c. Gather the record forms, stopwatch, clipboard, and pencils without erasers.
  - d. Arrange the testing site.
    - (1) Position chairs on opposite sides of a clean, level desk or table.
    - (2) Place materials out of the client's sight, but easily accessible to you, when not in use.
  - e. Ensure the testing area is--
    - (1) Well lit.
    - (2) Adequately ventilated.
    - (3) Quiet.
    - (4) Free of distractions.
    - (5) As comfortable as possible.
2. Prepare the client for the test.
- a. Greet the client and introduce yourself using your rank and last name.
  - b. Attempt to make the client feel relaxed. A little anxiety is normal.
  - c. Explain the purpose of the test.
    - (1) The WAIS-R is used as an aid in selection of a suitable therapy and a source of confirmation of a clinical diagnosis.
    - (2) Assure the client that results will be treated as confidential.
  - d. Explain the time limits to the client.
    - (1) Testing will normally take 60 to 90 minutes.

*NOTE:* The WAIS-R is composed of 11 tests, 6 verbal and 5 nonverbal that should be administered in a single session. Schedule two or more sessions within a day or two of each other, if all 11 tests cannot be administered at one session because of the physical condition or age of the client.

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- (2) Inform the client beforehand how breaks will be handled.

*NOTE:* Do not allow a break in the middle of a test.

- (3) A stopwatch will be used to time the arithmetic test and all five of the performance tests.

(4) Any time required to clarify instructions or repeat a question is counted as part of the time limit for that item.

*NOTES:* 1. If a response is probed, indicate a "Q" on the record form to show that any further response was elicited by questioning.

2. Allow the client to complete an item when the time has expired if he or she has almost finished. Do this in the interest of maintaining rapport, but score only the portion of the item that was completed within the time limit.

3. Establish and maintain rapport with the client.
  - a. Generate the client's interest in the test by explaining the importance of the test.
  - b. Present the tasks in a business-like, unhurried manner.
  - c. Make smooth transitions between test items.
  - d. Give encouragement making nonspecific remarks during the testing.

*EXAMPLES:* "Good."  
"That didn't take long."  
"Here is something different."

*NOTE:* It is inappropriate to tell the client a response is right or wrong.

- e. If the client's response is not clear, probe with a neutral statement or question such as--
    - (1) "Tell me more about that."
    - (2) "What do you mean?"
  - f. Make questioning nonthreatening and convey the need for more information rather than the feeling that the first response was wrong.
  - g. Make a general statement about what the client can expect to be on the tests for example, "You will be given a group of different tests. Some involve answering questions, while others will not involve words at all."
4. Administer the tests.

*NOTE:* There are six individual tests in the verbal scale: information, digit span, vocabulary, arithmetic, comprehension, and similarities. The performance scale consists of five tests: picture completion, picture arrangement, block design, object assembly, and digit symbol. The verbal and performance tests may be administered separately or together, but ordinarily the tests in the WAIS-R and the Record Form are presented in sequence to the client with the alternation of the tests.

a. Verbal Tests.

(1) Information. The information test assesses information from experience and education.

(a) Start with item 5 and award credit for items 1-4 if both items 5 and 6 are successfully completed. If the client does not pass items 5 and 6, administer items 1-4 before continuing with the test.

(b) Read each question precisely as it is written. If answers to questions are unclear or incomplete, ask the client to explain what he or she means or tell the client to give you more information about the answer.

(c) Record the client's exact response to each item in the appropriate space on the Record Form.

(d) Score 1 point for each accurate reply. The highest score possible is 29 points.

(2) Digit Span. The digit span test assesses immediate memory and requires the client to memorize and repeat a set of numbers forward (Digits Forward Test) or backward (Digits Backward Test).

(a) Tell the client to listen carefully to some numbers that you are going to recite to him or her and to repeat them to you after you have said them, specifying forward or backwards.

(b) Give the digits at the speed of one per second and let the pitch of your voice fall on the final digit of each trial. Give both trials each time, even if the client completes the first trial.

(c) Stop the test if the client is not successful on both trials of any element.

(d) Score every element as 2, 1, or 0. Give 2 points if the client successfully completes both trials. Give 1 point if the client successfully completes only 1 trial. Do not give the client any points if both trials are failed. The highest score possible is 14 points.

(3) Vocabulary. The vocabulary test requires abstract reasoning. The word list furnished with the examination will be used to perform the test.

(a) If a client appears to have limited verbal ability, start with the first item. For other clients, start with item 4. Provide full recognition for items 1 through 3 if the client passes items 4 through 8. If the client vaguely answers or misses any of the 4 through 8 items, administer items 1 through 3 before continuing the examination.

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(b) Position the word list so that the side which has items through 20 is facing the client. Tell the client to tell you the meaning of some of the words. For example, say a word and then ask what it means.

(c) Point to each word when you say it.

(d) With more able clients, you may pronounce the words, making sure that the pronunciation is one that you think the client will be familiar with.

(e) Ensure that the client locates each word on the word list. When 20 words have been tested, turn the list over to let the subject see the rest of the words.

(f) If you are not sure that the client understands what the word means, ask him or her to tell you more about it or explain it to you.

(g) All standard dictionary meanings or words are acceptable. Score a client a zero if he or she responds with a regional or slang usage that is not found in the dictionary. If you are not certain about a response, ask the client for another meaning.

(h) Record the client's responses in the correct space on the Record Form exactly as they are given.

(i) After the fourth consecutive incorrect response, discontinue the examination.

*NOTE:* Criteria for determining points given are stated in the WAIS-R Manual.

(4) Arithmetic. The arithmetic test requires abstract reasoning.

(a) Start with element 3 and then give credit for elements 1 and 2. If a client does not pass elements 3 and 4, administer elements 1 and 2 before continuing with the examination.

(b) Each problem has a time limit (as indicated in the WAIS-R Manual) which begins just after the problem has been read. You may repeat a problem one time if the client did not understand it. But, the timing starts with the end of the first reading of the problem.

(c) The client may not use a pencil or paper for any problem. The client may use his or her finger to "write" on the table.

(d) Record each of the client's responses in the proper space on the Record Form. When recording items 10 through 14, also record the time the client takes to answer the item.

(e) Discontinue the examination after 4 consecutive incorrect responses.

(f) Score 1 point for each correct reply. If the numerical quantity of an answer is right, award the client a point even if units, such as dollars and cents, are not given. If a right answer is also

spontaneously given within the time limit, give the client credit. For elements 10 through 14, give one bonus point per item if the response is rapid and correct.

(5) Comprehension. The comprehension test measures judgment and common sense.

(a) Start with item 1. Read each question slowly and clearly to the client. Repeat the question if you must, but make sure that you do not alter the wording. You should repeat the question if there is no response after 10 to 15 seconds.

(b) If the client is reluctant, give him or her encouraging remarks.

(c) If you are not sure what the client's response means, ask him or her to explain it further.

(d) For item number 1, you may give the client a clue to one correct answer. Two correct answers are required for 3 and 4 to receive full credit. If the client gives you one correct response but does not give another one spontaneously, ask him or her for another response. Only one second response may be requested by the examiner for each applicable item.

(e) Record the client's responses in the correct space on the Record Form exactly as they are given.

(f) Discontinue the examination after 4 consecutive incorrect responses.

(g) Score each item as 2, 1, or 0, depending on the degree of understanding and quality of response. The highest possible score is 32 points.

*NOTE:* Criteria for determining points given are stated in the WAIS-R Manual.

(6) Similarities. The similarities test assesses the ability of a client to recognize relationships between objects or ideas.

(a) Start with item 1. For each item ask the client how the items are alike. If the client has problems with the first item, you may offer clues to the correct response. Do not assist the client with any other items. But, if a response is unclear, you may ask the client what he or she means or to tell you a little more.

(b) Record the client's responses in the proper space on the Record Form exactly as they are given.

(c) Discontinue the examination after 4 consecutive incorrect responses.

(d) Score each item as 2, 1, or 0, depending on the degree of understanding and quality of response. The highest possible score is 28 points.

*NOTE:* Criteria for determining points given are stated in the WAIS-R Manual.

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### b. Performance Tests.

(1) **Picture Completion.** The picture completion test assesses the ability of a client to differentiate essential from nonessential details. The client is shown a series of pictures with missing items.

(a) Show the client a picture and ask him or her what is missing. If you receive a correct response, continue to show the pictures and ask what is missing. You may give the client clues if he or she misses the first two pictures. However, no further assistance may be given.

*NOTE:* If the client mentions an unessential missing item, you may ask him or her what is the most important thing that is missing. You may do this only one time.

(b) Allow a minimum of 20 seconds for each card.

(c) Discontinue the examination after 5 consecutive incorrect responses.

(d) Give the client 1 point for each correct response. The client will receive a point if the missing part is adequately described. The exact name does not have to be given. The missing part may also be pointed to, but, if the missing part is pointed to and the incorrect name is given, the client fails the item. The client may receive a maximum of 20 points.

(2) **Picture Arrangement.** The picture arrangement test assesses the ability of a client to differentiate essential from nonessential details. The client is given a series of pictures in a mixed-up order. The client is told to arrange them in an order that tells a logical story.

(a) For the first item, put the cards in numerical order in front of the client with the card marked "1" at the client's left.

*NOTE:* Printed numbers on the backs of the cards indicate the orders for laying out the cards.

(b) Explain to the client what story the pictures are to tell and that he or she is to place the cards in the correct order to tell the story.

(c) Allow the client 60 seconds to complete the task. If the client fails to accomplish the task, assist him or her. Then, place the cards in the original order and have him or her complete the task again.

(d) If the client fails to complete the first item, go ahead and begin with item 2.

(e) Continue with the card series until all 10 sets have been completed. Allow 60 seconds for each set of cards. If the client definitely understands the procedure and is proficient, you may shorten the time. You may allow 60 seconds for 3 and 4, 90 seconds for 5 through 8, and 120 seconds for 9 and 10.

(f) Give only one trial for items 2 through 10. Give no demonstrations of the correct order for any of these items.

(g) Stop the test if the client answers four consecutive items incorrectly after completing item 2.

(h) Give the client 2 points if he or she completes the first item correctly on the first attempt; give him or her 1 point if he or she completes it on the second attempt. For items 2 through 10 award 2 points for each correct arrangement completed within the time limits. Give 1 point for each acceptable variation completed within the time limit.

*NOTE:* There are two correct arrangements for items 8 and 10 and two acceptable variations for item 2 and one acceptable variation for items 5, 8, and 10.

(i) The highest possible score is 20 points.

(3) Block Design. The block design test assesses the ability of a client to perceive and analyze forms.

(a) For item 1, arrange four blocks in the design shown on card 1 and have the client arrange four other blocks in the same design (without exposing card 1 to the client, but leaving the model intact).

(b) For items 2 through 9, scramble the four blocks used by the client to form design 1 and give him or her cards 2 through 9 (one at the time), and tell him or her to construct the blocks in the same design as the card.

*NOTE:* You may demonstrate design 2 for the client, and then scramble the blocks and have him or her try it.

(c) Allow 60 seconds for each item.

(d) Start the timing for each try when the last word of the directions is given. Record on the Record Form the exact time it takes the client to finish each design, if it is within the time limit.

(e) Score the item as incorrect if the design is faulty or if it is not finished in the time allowed. If the client does not finish designs 1 and 2 in the given time, stop and allow him or her a second trial.

(f) Discontinue the test after 3 consecutive incorrect responses.

(g) Award 2 points for successfully completing the first trial and 1 point for completing the second trial for designs 1 and 2. For designs 3 through 9, give 4 points for each design correctly finished in the time limit. In addition, give a maximum of a 3 point bonus for each design that is quickly and perfectly performed. Do not administer credit for partially accurate or incomplete designs.

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(4) Object Assembly. The object assembly test assesses the ability of a client to put parts together into a familiar pattern. The client must put together a simple puzzle similar to a jigsaw puzzle.

(a) The time constraints for each item are shown on the Record Form. Timing starts when the last word of the directions has been given.

(b) Record the exact time it takes the client to complete the item.

(c) Make sure that you note the arrangement of the pieces at the end of the time limit, since points are given for partial arrangement. Stop the timing when the client is obviously finished.

(d) Give the entire test to all clients.

(e) The score for each item is equal to the amount of cuts properly connected, plus a maximum of 3 bonus points per item for quick, perfect performance. The highest possible score is 41 points.

*NOTE:* In the WAIS-R Manual, diagrams are marked with an "X" at each place where there is a joining of two pieces, indicating the total number of points possible.

(5) Digit Symbol. The digit symbol test is a code substitution test. The client must be provided with a smooth drawing surface.

*NOTE:* If the client is left handed, allow the use of another scoring sheet folded over as the guide for the codes.

(a) Place the digit symbol worksheet in front of the client and point to the "key" above the test items. Point out that each box has a number in the upper part of the box and a symbol in the lower part of the box.

(b) Indicate to the client where the seven sample boxes are.

(c) Ask the client to draw the corresponding symbol below the numbers in the sample boxes, referring to the "key" boxes for which symbols go with which numbers.

*NOTE:* You may assist the client with the sample items, making corrections, if necessary and reviewing use of the key.

(d) Direct the client to begin with row 1 and work each item in sequence until you tell him or her to stop.

(e) Time the client for 90 seconds and have him or her stop when the 90 seconds are complete.

(f) Score 1 point for each of the items that have been filled in correctly. Do not include the sample items. Do not give credit for items completed out of sequence.

(g) Use the digit symbol worksheet scoring stencil to check the client's responses and then record the information on the Record Form.

(h) The highest possible score is 93.

5. Terminate the testing session.

a. Direct the client to discuss any questions about the test with the referral source.

b. Escort the client back to the ward if he or she is a psychiatric inpatient.

6. Score the WAIS-R.

a. Calculate the raw scores.

(1) Score the individual tests according to directions in the WAIS-R Manual.

(2) Transfer test scores to the appropriate space in the Summary Section on the cover of the Record Form.

b. Obtain Scaled Scores.

(1) Convert raw scores to scaled scores using the Table of Scaled Score equivalents to the left of the Summary Section.

*NOTE:* Scoring is a vital element of the WAIS-R. All addition should be checked and the WAIS-R Manual referred to for further instructions.

(2) Obtain sums of scaled scores on all 11 tests.

(3) Determine IQ equivalents utilizing Table 20 in the WAIS-R Manual.

(4) Plot a profile of the client's scaled scores on the Table of Scaled Score Equivalents on the cover of the Record Form.

(a) Circle the raw score for each test.

(b) Draw a line to connect the circles.

7. Prepare the Test Session Report.

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*NOTE:* This report is in a narrative format and written either in the order in which the information occurred or broken down into subtopics grouping similar information.

- a. The following information must be included:
  - (1) Incidents that rendered the test data invalid.
  - (2) Client behaviors observed during the test session.
  - (3) Problems encountered and remedial action taken.
  - (4) Client's mood, emotional state, and significant personality traits as well as impressions drawn from them.
  - (5) Client's degree of cooperativeness.
- b. Submit the report to the referring psychologist.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Prepare for the WAIS-R test.	P	F
2. Prepare the client for the WAIS-R test.	P	F
3. Establish and maintain rapport with the client.	P	F
4. Administer the WAIS-R test.	P	F
5. Terminate the testing session.	P	F
6. Score the WAIS-R test.	P	F
7. Prepare the Test Session Report.	P	F

<b>REFERENCES:</b>	<b><i>Required</i></b>	<b><i>Related</i></b>
	WAIS-R Manual	None

081-832-1011

**RESPOND TO AN AGITATED PATIENT**

**CONDITIONS**

A patient is verbally belligerent, hostile, and exhibiting behavior that indicates he or she is beginning to lose control. Necessary materials and equipment: clinical record and mechanical restraints.

**STANDARDS**

Perform the appropriate interventions in response to an agitated patient, starting with the least restrictive form.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

- |  |               |
|--|---------------|
| <ol style="list-style-type: none"> <li>1. Utilize the appropriate interventions beginning with the least restrictive form.             <ol style="list-style-type: none"> <li>a. Verbal intervention--least restrictive.                 <ol style="list-style-type: none"> <li>(1) Approach the patient in a calm manner, aware of the need for an enlarged "Buffer Zone".</li> </ol> </li> </ol> </li> </ol> | <p>P    F</p> |
|--|---------------|

*NOTE:* Agitated patients tend to need extra personal space between themselves and the mental health specialist to avoid feeling threatened.

- (2) Maintain eye contact.
- (3) Present a nonthreatening posture.
  - (a) Place yourself at an angle to the patient, keeping a distance of at least one leg length (3 feet) from the patient as a personal safety margin.
  - (b) Keep your hands in plain view, at your sides, if possible.

*NOTE:* Avoid placing hands on hips, folding arms against your chest, or clenching your fists.

- (4) Speak in a firm nonthreatening tone of voice with moderate volume.
- (5) Encourage the patient to gain self-control.

**Performance Measures**

**Results**

(a) Allow the patient to express his or her feelings, without getting into an argument or power struggle.

*NOTE:* Let the patient know he or she can express feelings such as anger in an acceptable way. You must remain in control without responding with anger or defensiveness.

(b) Set limits on his or her behavior by providing the patient with clear expectations regarding acceptable behavior.

(c) Inform the patient of enforceable consequences if his or her behavior is not controlled.

(d) Offer the patient positive reinforcement for complying with the limits set.

b. Chemical intervention--the use of medication to sedate the patient.

*NOTE:* The medication must be ordered, verbally or in writing, by a physician.

(1) Use when a patient does not respond to verbal intervention.

(2) Utilize in conjunction with other forms of intervention, such as verbal or physical.

*NOTE:* Chemical intervention should not be used to discipline or punish the patient, or for the convenience of the staff.

c. Physical intervention--most restrictive form.

(1) Use as a last resort.

(a) Use to protect the patient from injuring himself or herself or others.

(b) Use to prevent serious disruption of the therapeutic environment.

(2) Manual restraint--controls the patient physically. (See task 081-832-1012.)

(3) Mechanical restraint--restricts or limits the patient's movement through use of mechanical restraints. (See task 081-832-1013.)

(4) Seclusion--places a patient in a hazard-free room. (See task 031-832-1025.)

<b>Performance Measures</b>	<b>Results</b>
<p>2. Perform psychological aftercare for the patient who has lost control.</p> <p style="padding-left: 40px;">a. Explain the staff's responsibility to take action to control the patient's behavior, after the patient has failed to control himself or herself.</p> <p style="padding-left: 40px;">b. Reorient the patient to the behaviors and circumstances that necessitated the staff action.</p> <p style="padding-left: 40px;">c. Point out similar behavior patterns and circumstances that have precipitated a loss of control.</p> <p style="padding-left: 40px;">d. Discuss possible alternatives to the patient's previous means of coping.</p> <p style="padding-left: 40px;">e. Negotiate with the patient for changes in his or her behavior to promote more effective coping skills.</p> <p style="padding-left: 40px;">f. Give the patient support, respect, and encouragement to assist him or her in learning to cope.</p>	<p>P F</p>
<p>3. Record and report the patient's conversation and behavior and the staff interventions.</p> <p style="padding-left: 40px;">a. Report the incident to your supervisor, if not already informed of the situation.</p> <p style="padding-left: 40px;">b. Document the patient's behavior.</p> <p style="padding-left: 40px;">c. Document the staff interventions.</p>	<p>P F</p>

*NOTE:* Documentation is done on SF 509 or SF 510 IAW local policy.

**REFERENCES:** None

081-832-1012

**ASSIST IN MANUAL RESTRAINT PROCEDURES**

**CONDITIONS**

A patient is acting out by being physically abusive. Verbal and chemical interventions have not been effective. The assistance of at least three other staff members is available. Necessary materials: clinical record and SF 509 or SF 510.

**STANDARDS**

Manually restrain the patient without causing undue pain or injury to the patient.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

*NOTE:* Manual restraint means to physically control the patient. Doctor's orders are required. When a patient must be manually restrained in the absence of doctor's orders, the authorization must be obtained by supervisory personnel immediately after the patient is restrained.

- |   |   |   |
|---|---|---|
| 1. Obtain assistance.   | P | F |
| a. Use a minimum of four personnel, to include yourself, to manually restrain a patient of moderate stature and strength. |   |   |
| b. Use additional personnel to assist in the restraint depending on the situation and the availability of staff.          |   |   |
| c. Make a plan with the other team members and appoint a team leader, if time permits.                                    |   |   |
| 2. Remove sharp and/or dangerous items (name tags, watches, eyeglasses, and pens), if time permits.                       | P | F |
| 3. Clear the other patients from the immediate area, if possible.   | P | F |
| 4. Approach the patient.  | P | F |
| a. The team leader approaches the patient from the front.   |   |   |

**Performance Measures**

**Results**

- (1) Talk to the patient, causing the patient to focus attention on you.
- (2) Move toward the patient and get as close as possible without the patient being able to strike you.
- b. Direct the other staff members to approach the patient from each side and the back.
- c. Modify action to fit the situation.

5. Immobilize the patient.

P F

- a. Move on an agreed upon command.
- b. Direct simultaneous assistance from the other staff members.
- c. Take the patient down, lowering the patient to the floor, face down.
- d. Control the patient's limbs.
  - (1) Straighten the patient's arms along his or her sides, palm up.

*NOTE:* This reduces the patient's ability to get leverage and resist the restraint.

- (2) Straighten the patient's legs to keep the patient from kicking.

*NOTE:* Grasp the patient's limbs above or below the joints to avoid undue injury or pain to the patient.

6. Assess the need for additional control.

P F

- a. Consult with the supervisor if time and the situation permit.
- b. Determine if additional control is necessary by considering--
  - (1) The patient's history of assaultive or abusive behavior.
  - (2) The patient's current level of functioning and ability to gain control.

7. Intervene with additional control, if determined to be necessary.

P F

- a. Apply mechanical restraints. (See task 081-832-1013.)

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

- b. Place the patient in a seclusion room. (See task 081-832-1025.)
- 8. Record and report the patient's conversation and behavior and the staff interventions. P F
  - a. Report the incident to the supervisor, if not already informed of the situation.
  - b. Document the patient's behavior that resulted in manual restraint.
  - c. Document the patient's behavior and response to being manually restrained.
  - d. Document staff interventions prior to and after manually restraining the patient.

*NOTE:* Documentation is done on SF 509 or SF 510 IAW local policy.

**REFERENCES:** None

081-832-1013

## ASSIST IN MECHANICAL RESTRAINT PROCEDURES

### CONDITIONS

A patient is acting out by being physically abusive. Verbal and chemical interventions have not been effective. The patient has just been manually restrained, and it has been determined that mechanical restraints are required. The assistance of at least three other staff members is available. Necessary materials and equipment: complete set of leather restraints and two additional leather belts, gauze for padding, and clinical record.

### STANDARDS

Restrict the patient's movement using mechanical restraints, without causing undue pain or harm to the patient. Apply the cuffs tightly enough to hold the patient securely, without interfering with circulation.

### TRAINING AND EVALUATION

#### *Training Information Outline*

*NOTE:* Mechanical restraint is the restricting or limiting of the patient's movement through the use of restraints. Doctor's orders are required for the use of mechanical restraints. When a patient must be mechanically restrained in the absence of doctor's orders, the authorization must be obtained by supervisory personnel immediately after the patient is restrained.

1. Obtain the necessary equipment.
  - a. Complete set of leather restraints.

*NOTE:* If the patient is of slender build, the cuffs to the restraint set should be padded with gauze or similar material to prevent the patient from slipping out of the restraint cuffs.

- (1) Two leather wrist cuffs.
- (2) Two leather ankle cuffs.
- (3) Two leather belts, one long and one short.
- (4) One restraint key.
- b. Two additional leather belts if the patient is to be restrained to a bed.

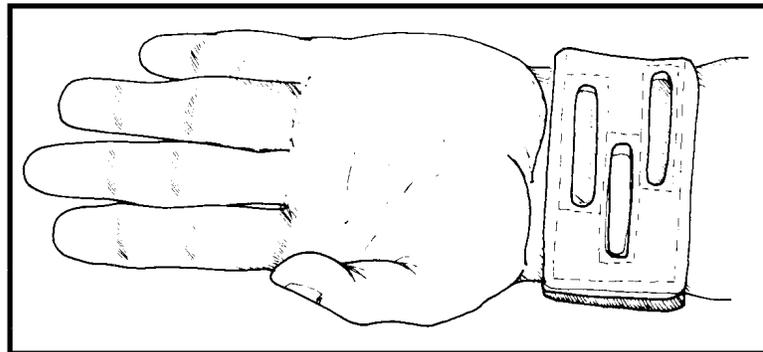
## STP 8-91X14-SM-TG

### 2. Apply 2-point restraints.

#### a. Place wrist cuffs around the patient's wrists.

(1) The cuffs must be tight enough to hold the patient securely without interfering with blood circulation.

(2) The cuffs should be positioned on the patient's wrists so the metal loop is on the inner side of the wrist. (See Figure 3-5.)



**Figure 3-5**

b. Secure the wrist cuffs by passing the long leather belt through the wrist cuff loop, around the patient's stomach, and through the other wrist cuff loop.

c. Adjust the belt for the desired movement, and then lock the buckle in place at the rear of the patient.

*NOTE:* This is done on ambulatory patients to discourage them from attempting to unlock the buckle.

#### d. Place ankle cuffs around the patient's ankles.

(1) The cuffs should be tight enough to hold the patient securely without interfering with circulation.

(2) The metal loops on the cuffs should be positioned to the inside of the patient's ankles.

e. Secure the ankle cuffs by passing the short leather belt through the ankle cuff loops.

f. Adjust the belt for the desired movement.

g. Lock the buckle in place.

h. Transport the patient, if necessary, with the assistance of other staff members.

*NOTE:* This is done if the patient is to be moved to a bed or seclusion room.

- (1) Carry the patient face down, head first.
- (2) Support the chest and thighs, if a litter is not available.

*NOTE:* It is very important that coordination and teamwork be maintained to prevent patient and staff injury. If transporting the patient without a litter, locking hands is recommended, so the patient does not slip from the transporters' hands.

3. Apply 4-point restraints.

*NOTE:* This is done when the patient is to be restrained to a bed. Four belts are needed.

- a. Position the patient on the bed.

*NOTE:* The patient is restrained to the bed lying on his or her stomach if he or she is combative, since this allows for less movement and decreases the leverage the patient can exert. The patient is also positioned on the stomach if there is a risk of aspiration. However, if these are not an issue, the patient may be more comfortable and feel more secure if positioned lying on his or her back.

- b. Explain to the patient that he or she will be restrained to the bed.
- c. The team leader will direct the release of one limb at a time while maintaining control of the other limbs.
- d. Secure each wrist cuff by passing a leather belt through each wrist cuff loop and around the bed frame.

*NOTE:* Ensure the belts are anchored to a secure part of the bed that will not easily break or move.

- e. Adjust the belts for desired movement.
- f. Lock the buckles.
- g. Secure each ankle cuff by passing a leather belt through each ankle cuff loop and around the bed frame.
- h. Adjust the belts for desired movement.
- i. Lock the buckles in place.

4. Perform follow-up care for the restrained patient.

- a. Explain the reason for the restraints being applied.

**STP 8-91X14-SM-TG**

- b. Check the patient for injuries.
- c. Observe the patient closely.

*NOTE:* The patient should be placed on 1:1 observation when in restraints. (See task 081-832-1008.)

- d. Provide for basic needs.
  - (1) Elimination.
  - (2) Meals.
  - (3) Fluids.
- e. Perform hygiene care, as needed.
- f. Check the coloration and warmth of the patient's extremities for circulation impairment.
- g. Massage the extremities as you perform range of motion exercises with the patient's extremities.
- h. Take the patient's vital signs IAW doctor's orders.
- i. Encourage the patient to talk about his or her thoughts and feelings.
- j. Discuss the behavioral expectations for removal from restraints.

*NOTE:* The mental health specialist will not remove restraints without consulting with the supervisor.

- 5. Record and report the patient's conversation and behavior and the staff interventions.
  - a. Report unusual behavior or abnormalities to the supervisor immediately.

*NOTE:* This will include any abnormalities you observe when performing follow-up care.

- b. Document the patient's behavior that resulted in placement into restraints.
- c. Document the patient's behavior and response after placement into restraints.
- d. Document the staff interventions prior to and after applying restraints to the patient.

*NOTE:* Frequency of documentation and where documentation is done will be IAW local policy.

***Evaluation Preparation***

*Setup:* Prepare a patient for the soldier to restrain by simulating one or more scenarios and conditions. The patient will be coached to resist the restraint procedure without causing injury to himself or herself or others.

*Brief soldier:* Tell the soldier to mechanically restrain the patient with assistance from three other staff members.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>
1. Obtain the necessary equipment.	P    F
2. Apply 2-point or 4-point restraints, as applicable.	P    F
3. Perform follow-up care for the restrained patient.	P    F
4. Record and report the patient's behavior and conversation and the staff interventions.	P    F

**REFERENCES:** None

081-832-1014

**INVOLVE PATIENTS IN THERAPEUTIC RECREATIONAL ACTIVITIES**

**CONDITIONS**

Psychiatric patients on the ward appear to be bored and restless. There are no scheduled activities. Necessary materials and equipment: recreational equipment and games, and clinical records.

**STANDARDS**

Involve the patients in therapeutic recreational activities which are related to their interests and within the limitations of their physical and emotional capabilities.

**TRAINING AND EVALUATION**

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Determine the patients' areas of interest.	P	F
a. Explain the activities that are available to the patients.		
b. Encourage feedback from the patients regarding the activities they would be interested in participating in.		
2. Obtain the necessary equipment for the activity, if necessary.	P	F
3. Escort the patients to the activity, if necessary. (See task 081-832-1010.)	P	F
4. Explain the instructions or rules for the activity.	P	F
5. Encourage and guide patient participation.	P	F
a. Attempt to instill in each patient a desire to participate by demonstrating an enthusiastic attitude toward the activity.		
b. Give the patients encouragement and support during the activity.		
c. Assist patients who are having difficulty participating in the activity.		
d. Participate in the activity, only after taking into consideration whether staff coverage of the activity permits adequate supervision of all patients, to include nonparticipants.		

<b>Performance Measures</b>	<b>Results</b>	
6. Observe each patient's behavior, noting his or her--	P	F
a. Interest and participation in the activity.		
b. General attitude toward participating in the activity.		
c. Interactions with other patients and staff.		
7. Escort the patients back to the ward, if necessary. (See task 081-832-1010.)	P	F
8. Return the equipment, if applicable.	P	F
9. Record significant observations about each patient in his or her clinical record.	P	F

**REFERENCES:** None

081-832-1023

**DEVELOP A THERAPEUTIC RELATIONSHIP WITH A PATIENT**

**CONDITIONS**

You are assigned to care for and interact with a patient.

**STANDARDS**

Establish rapport and maintain a therapeutic relationship in all interactions with the patient.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

*NOTE:* Therapeutic relationships imply the establishment of a warm, trusting relationship between the mental health specialist and the patient, for the purpose of helping the patient.

- |  |        |
|--|--------|
| 1. Establish rapport with the patient.   | P    F |
| a. Demonstrate warmth, making the patient feel cared for and comfortable.  |        |
| (1) Respect the patient's worth as a person and as an individual.  |        |
| (2) Give the patient freedom to be himself or herself.   |        |
| (3) Care and value the patient for his or her potential without allowing one's own feelings to interfere in evaluating the patient's behavior. |        |
| (4) Share the patient's joy, aspirations, sadness, and failures.   |        |
| b. Demonstrate empathy and the ability to appreciate and be aware of the patient's feelings, by--  |        |
| (1) Recognizing the patient's expression of emotions.  |        |
| (2) Responding with sensitivity to the patient's full range and intensity of feelings.   |        |
| (3) Communicating an understanding of the patient's feelings.  |        |
| c. Demonstrate genuineness--the ability to be oneself.   |        |

**Performance Measures**

**Results**

- (1) Give open, honest responses.

*NOTE:* This does not mean that the mental health specialist expresses his or her feelings at all times--only that the feelings are not denied.

- (2) Be open to both pleasant and unpleasant feelings and experiences.
- (3) Be nondefensive.
- (4) Ensure what you verbalize is what is felt or thought.

2. Demonstrate characteristics of a therapeutic relationship in interactions with the patient.

P F

- a. Ensure the purpose of the relationship is to help the patient.
- b. Accept the patient without being judgmental.
- c. With input from the patient, set goals which are specific, known to the patient, and appropriate to the patient's needs.
- d. Keep the relationship focused on goals.
- e. Disclose only thoughts and feelings of your own which will help the patient, but allow the patient to openly discuss intimate thoughts and emotions.
- f. Plan and discuss termination of the relationship with the patient, with awareness throughout the relationship that it is time-limited and based on attainment of goals.

**REFERENCES:** None

081-832-1024

**CARE FOR A PATIENT RECEIVING ELECTROCONVULSIVE THERAPY**

**CONDITIONS**

A severely depressed patient has signed a consent form to receive electroconvulsive therapy (ECT). The doctor's order has been received. Necessary materials and equipment: blood pressure cuff, stethoscope, and the clinical record.

**STANDARDS**

Care for a patient before, during, and after ECT.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

- |  |   |   |
|--|---|---|
| 1. Care for a patient before ECT.  | P | F |
| a. Inform and remind the patient of the need to remain NPO (nothing by mouth) after 2400 hours the night prior to treatment. |   |   |
| b. Ensure the patient removes dentures, prosthetic devices, jewelry, and glasses, as applicable.                             |   |   |
| c. Ensure the patient empties his or her bowel and bladder immediately prior to the treatment.                               |   |   |
| d. Display a warm, supportive attitude to reduce the patient's apprehension.   |   |   |
| (1) Provide realistic reassurance to the patient.  |   |   |
| (2) Answer questions regarding the treatment, procedures, and effects.   |   |   |
| 2. Care for the patient during ECT.  | P | F |
| a. Escort the patient to the treatment area.   |   |   |
| b. Assist the patient in getting onto the stretcher into a supine position.  |   |   |
| c. Put the siderails up.   |   |   |

**Performance Measures****Results**

- d. Stay with the patient during the treatment.
- e. Take the patient's blood pressure, pulse, and respirations as directed by the physician.
- f. Notify the physician of any changes in the patient's blood pressure, pulse, and respirations.
- g. Assist with equipment, as directed.
- h. Observe the patient's limbs for seizure activity.

*NOTE:* Due to muscle relaxant medications given to the patient prior to the treatment, it is usually difficult to see any movement. A slight flexion of the feet or movement of the toes may be the extent of seizure activity noted.

## 3. Care for the patient after ECT.

P F

- a. Speak quietly to the patient as he or she becomes alert. Explain what has happened and reduce the patient's fears by reassuring him or her that the confusion and memory loss are only temporary.
- b. Check the patient for side effects of ECT.
  - (1) Nausea.
  - (2) Headache.
  - (3) Amnesia.
  - (4) Disorientation.
- c. Orient the patient to time, place, and events.
- d. Take the patient back to his or her hospital room to recover.
- e. Offer the patient food and drink, as tolerated.
- f. Encourage the patient to--
  - (1) Express his or her feelings about the treatment.
  - (2) Return to normal activities as soon as possible.

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

4. Document the care performed, the patient's response, and the staff interventions.

P F

a. Document the patient's response during the treatment.

b. Document the patient's level of awareness, communication, and activity level after the treatment.

c. Document staff interventions performed.

*NOTE:* Documentation is done on SF 509 or SF 510 IAW local policy.

**REFERENCES:** None

081-832-1025

**PLACE A PATIENT IN SECLUSION**

**CONDITIONS**

A psychiatric patient has been ordered to be placed into seclusion due to assaultive behavior and causing serious disruption to the therapeutic environment. Verbal and chemical interventions were utilized and were not effective. You are assigned to assist in placing the patient into seclusion and to monitor him or her while in seclusion. Other staff members are available to assist you. Necessary materials: clinical record.

**STANDARDS**

Place a patient into seclusion. Monitor the patient to prevent harm to himself or herself or others. Document all related interventions accurately. Perform steps 1 through 5 in order.

**TRAINING AND EVALUATION**

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Explain to the patient the reason he or she is being placed in seclusion.	P F
2. Search the patient and room for objects that might be harmful.	P F
3. Remove the patient's shoes, jewelry, and glasses, if applicable.	P F
4. Assist in placing the patient into seclusion.	P F
a. Escort the patient to seclusion, if he or she is cooperative.	
b. Follow the procedures for manual and/or mechanical restraint, if the patient is uncooperative. (See tasks 081-832-1012 and 081-832-1013.)	
5. If the patient is not mechanically restrained, ensure that staff members leave the seclusion room one at a time, by backing out. Quickly close the door after the last staff member leaves.	P F
6. Do steps 1 through 5 in order.	P F
7. Observe the patient frequently and provide for his or her basic needs.	P F

*NOTE:* The patient should be checked at least every 15 minutes.

## STP 8-91X14-SM-TG

### Performance Measures

### Results

- a. Observe the patient's behavior.
- b. Call for assistance, if needed.
- c. Directly intervene if the patient is in danger of causing harm to himself or herself or others.

*NOTE:* When entering the seclusion room, have the patient stand at the far wall, and ensure one staff member enters the room at a time, if the patient is not restrained. Do not enter alone.

- d. Offer food and fluids at regular intervals.

*NOTE:* Paper plates and cups should be used and finger foods provided, if possible. When the patient finishes eating, ensure all remaining items are removed.

- e. Provide the opportunity to the patient for elimination.

(1) Give the patient a bedpan or urinal to use, or escort him or her to the latrine if mechanically restrained.

(2) Obtain assistance and enter the seclusion room to give the patient a bedpan or urinal to use, if the patient is not mechanically restrained.

*NOTE:* Remain with the patient and remove the bedpan or urinal when the patient is finished with it.

- f. Perform personal hygiene, as needed.

### 8. Talk with the patient.

P F

- a. Allow the patient to express his or her thoughts and feelings.
- b. Discuss behavioral expectations for removal from seclusion.
- c. Offer the patient encouragement and support.

### 9. Record and report the patient's conversation and behavior and the staff interventions.

P F

- a. Report unusual behavior or abnormalities to the supervisor.
- b. Document the specific patient behavior which resulted in his or her placement into seclusion.

**Performance Measures**

**Results**

c. Document the patient's response to seclusion and to the staff interventions performed.

d. Document the staff interventions and nursing care performed.

*NOTE:* Frequency of documentation and where documentation is done will be IAW local policy.

**REFERENCES:** None

**MONITOR A PATIENT'S RESPONSE TO PSYCHOTROPIC MEDICATIONS**

**CONDITIONS**

A patient is prescribed a form of psychotropic medication. Necessary materials: clinical record.

**STANDARDS**

Recognize the effects and side effects of psychotropic medications and perform necessary interventions.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Identify the trade names and intended uses of commonly used psychotropic medications.
  - a. Antipsychotic medications--used primarily to treat psychotic symptoms, also used to treat extreme behaviors such as rage and agitation.
    - (1) Thorazine.
    - (2) Haldol.
    - (3) Navane.
    - (4) Prolixin.
  - b. Antidepressant medications--used to treat depression.
    - (1) Tricyclics.
      - (a) Elavil.
      - (b) Tofranil.
    - (2) Tetracyclic--Ludiomil.
    - (3) MAO inhibitors.
      - (a) Nardil.
      - (b) Parnate.

- (4) Desyrel.
  - c. Antianxiety medications--used to treat anxiety and symptoms of acute alcohol withdrawal.
    - (1) Librium.
    - (2) Valium.
  - d. Antimania medication (Lithium Carbonate)--used to treat mania and bipolar disorders.
2. Recognize the desired effects of the psychotropic medications on the patient.
- a. Antipsychotic medication.
    - (1) A decrease in disorganized thoughts and/or aggressive behavior.
    - (2) A decrease in, or absence of, violent behavior.

*NOTE:* Optimal desired effects may take weeks or months of being on the medication.

- b. Antidepressant medication.
  - (1) A decrease in feelings of depression.
  - (2) An increase in energy level.

*NOTE:* Full therapeutic response may take 3 to 4 weeks of being on the medication.

- c. Antianxiety medication.
  - (1) A reduction in symptoms of anxiety--restlessness, irritability, hyperalertness.
  - (2) A reduction in symptoms of acute alcohol withdrawal.
- d. Antimania medication.
  - (1) Diminish the excitement, euphoria, and insomnia associated with mania.
  - (2) Establish a stable mood state.

*NOTE:* The effects are closely related to therapeutic serum levels.

3. Recognize the unpleasant side effects a patient on psychotropic medication is experiencing and intervene accordingly.

## STP 8-91X14-SM-TG

*NOTE:* The mental health specialist should discuss common side effects with the patient and encourage him or her to report any unusual signs or symptoms.

a. Antipsychotic medication.

- (1) Dry mouth. Offer the patient fluids or suggest he or she suck on sugarless candy or chew gum.
- (2) Constipation. Encourage the patient to increase fluid intake, fiber intake, and activity level.
- (3) Blurred vision. Reassure the patient that this is a temporary side effect.
- (4) Drowsiness.
  - (a) Reassure the patient that this may diminish as tolerance to the medication develops.
  - (b) Caution the patient to avoid activities requiring mental alertness, such as driving.
- (5) Urinary retention. Instruct the patient to report changes in frequency and amount of urination.
- (6) Weight gain.
  - (a) Encourage proper nutrition and dietary habits.
  - (b) Provide an opportunity to increase activity level.
- (7) Orthostatic hypotension.
  - (a) Instruct the patient to rise slowly when getting up.
  - (b) Monitor the patient's blood pressure as directed.

*NOTE:* This is normally done with the patient sitting and in a supine position.

- (8) Photosensitivity.
  - (a) Caution the patient to limit direct exposure to the sun.
  - (b) Encourage the patient to wear sunglasses, sunscreen, and a hat in the sun.
- (9) Extrapyramidal side effects.

*NOTE:* The technician should immediately report these symptoms to the nurse so the symptoms can be treated with medication.

(a) Acute dystonia. The patient may experience involuntary muscular movements, such as tongue protrusion, grimacing, gait abnormalities, abnormal eye movements, and neck twisting.

(b) Akathisia. The patient may experience restlessness, uncontrolled pacing, difficulty sitting still, and agitation.

(c) Tardive dyskinesia. The patient may experience involuntary movement of the extremities and trunk, single muscle jerks or tics, tongue protrusion, and chewing motion of the mouth.

(d) Pseudoparkinsonism. The patient may experience tremors, shuffling gait, masklike expression, drooling, and cogwheel rigidity.

b. Antidepressant medication.

(1) Drowsiness.

(a) Reassure the patient that this may diminish as tolerance to the medication is developed.

(b) Caution the patient to avoid activities which require mental alertness, such as driving.

(2) Constipation. Encourage the patient to increase fluid intake, fiber intake, and activity level.

(3) Blurred vision. Reassure the patient that this is a temporary side effect.

(4) Weight gain.

(a) Encourage proper nutrition and dietary habits.

(b) Provide the opportunity to increase activity level.

(5) Orthostatic Hypotension.

(a) Instruct the patient to rise slowly when getting up.

(b) Monitor blood pressure as directed.

(6) Increased potential for seizures. Observe the patient for any fine tremors or ataxia (loss of coordination of muscles).

(7) Sexual dysfunction.

(a) Demonstrate sensitivity regarding the patient's reluctance to discuss the sexual problems he or she is experiencing.

## STP 8-91X14-SM-TG

(b) Observe the patient compliance with medication treatment, as the patient may discontinue the medication on his or her own instead of reporting this side effect.

(8) Hypertensive crisis--caused when a patient on MAO inhibitors eats tyramine-rich foods.

(a) Instruct and remind the patient to avoid foods containing tyramine if taking an MAO inhibitor.

*NOTE:* A list of foods containing tyramine should be made available to the patient.

(b) Inform the patient to report immediately any symptoms of a tyramine-induced hypertensive crisis, such as headaches, palpitations, nausea, or vomiting.

c. Antianxiety medication.

(1) Drowsiness.

(a) Reassure the patient that this may diminish as tolerance to the medication is developed.

(b) Caution the patient to avoid activities which require mental alertness, such as driving.

(2) Ataxia. Alert the patient to the danger of potential injury.

(3) Itchy rash. Report the condition to the nurse.

(4) Gastric irritation. Have the patient take medication with meals or a light snack, if possible.

(5) Central nervous system depression, when combined with other depressants or alcohol. Seek assistance immediately.

d. Antimania medication.

*NOTE:* Patients on lithium carbonate must be reminded of the signs of lithium toxicity, the importance of having serum levels measured, and taking in adequate amounts of fluids.

(1) Tremors. Encourage the patient to decrease caffeine consumption.

(2) Diarrhea. Encourage the patient to increase fluid intake.

(3) Weight gain.

(a) Encourage proper nutrition and dietary habits.

(b) Provide an opportunity to increase activity level.

(4) Nausea. Have the patient take medication with food, if possible.

- (5) Polyuria (excessive urination).
    - (a) Monitor the patient's output of urine.
    - (b) Encourage the patient to increase intake of fluids.
  - (6) Toxic levels may induce symptoms such as slurred speech, dizziness, confusion, and impaired consciousness. Report these symptoms immediately to the nurse.
4. Report and record observed effects and side effects of the psychotropic medication.
- a. Report abnormal observations to the nurse.
  - b. Document observed effects and side effects in the patient's clinical record IAW local policy.

***Evaluation Preparation***

*Setup:* For training and evaluation, have another soldier act as the patient. Select a scenario that will allow you to evaluate the soldier. Coach the simulated patient on which actions you want to evaluate.

*Brief soldier:* Tell the soldier to intervene when recognizing effects and side effects of a specific psychotropic medication on the patient. Ask the soldier to describe and explain his actions.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Identify the purpose and the trade names of commonly used psychotropic medications.	P	F
2. Recognize the desired effects of the psychotropic medications on the patient.	P	F
3. Recognize the unpleasant side effects of the psychotropic medications and intervene accordingly.	P	F
4. Report and record the observed effects and unpleasant side effects of psychotropic medications.	P	F

**REFERENCES:** None

081-832-1001

ENSURE A PATIENT'S FUNDS AND VALUABLES ARE SECURED

CONDITIONS

A patient admitted to a psychiatric ward has funds and valuables with him or her. The patient trust fund (PTF) representative is available. Necessary materials and equipment: DA Form 3696, clinical record, and patient identification plate, if available.

STANDARDS

Ensure that the patient's funds and valuables are secured.

TRAINING AND EVALUATION

*Evaluation Guide*

Performance Measures

Results

- |   |   |   |
|---|---|---|
| 1. Make contact with the PTF custodian.   | P | F |
| a. If the patient is allowed to leave the ward, escort the patient to the PTF. (See task 081-832-1010.) |   |   |
| b. If the patient is restricted to the ward, summon the PTF custodian to the ward.                      |   |   |

*NOTE:* After duty hours call the designated PTF representative to come to the ward.

- |   |   |   |
|---|---|---|
| 2. Stamp DA Form 3696, in duplicate, with the patient identification plate, if available. | P | F |
|---|---|---|

*NOTE:* If DA Form 3696 is completed by a designated representative, it is done in triplicate. If the patient identification plate is not available, write in the required patient information.

- |  |   |   |
|--|---|---|
| 3. Ensure the patient's funds and valuables are inventoried.   | P | F |
| a. Ensure a description of each item is entered on DA Form 3696.   |   |   |
| b. Witness the transaction, if the patient is mentally capable and willing to assist the PTF custodian with the inventory and sign DA Form 3696. |   |   |
| c. Assist the PTF custodian with the inventory and sign all copies of DA Form 3696, if the patient is unable or unwilling to sign it.            |   |   |

**Performance Measures**

**Results**

*NOTE:* Enter a brief statement as to why the patient's signature was not obtained on the PTF copy of DA Form 3696.

4. Secure the patient's copy of DA Form 3696.

P F

a. Ensure the patient receives a copy of DA Form 3696, if the patient is capable of keeping it secure.

b. Place the patient's copy of DA Form 3696 in the clinical record, if the patient is not capable of securing it.

*NOTE:* Personal weapons, to include pocket knives (with blades beyond the length permitted by law or regulations), and any other items considered a menace to safety or health, will be turned over to the Commander, Medical Holding Unit, or his or her designated representative, and a receipt will be obtained. Any government property (government owned or organizational equipment) should be returned to the patient's unit, if possible.

**REFERENCES:**

*Required*

*Related*

None

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081-832-1002

ENSURE A PATIENT'S PERSONAL EFFECTS ARE SECURED

CONDITIONS

A patient admitted to the psychiatric ward has brought clothing, baggage, and other personal items. The patient clothing room clerk or designated representative is available. Necessary materials and equipment: DA Form 4160, DD Form 599, clinical record, and patient identification plate, if available.

STANDARDS

Ensure that the patient's personal effects are secured.

TRAINING AND EVALUATION

*Evaluation Guide*

Performance Measures

Results

- |  |        |
|--|--------|
| 1. Make contact with the patient clothing room clerk.<br><br>a. If the patient is allowed to leave the ward, escort the patient to the patient clothing room. (See task 081-832-1010.)<br><br>b. If the patient is restricted to the ward, summon the clothing room clerk to the ward. | P    F |
|--|--------|

*NOTE:* After normal duty hours, call the patient clothing room designated representative.

- |   |        |
|---|--------|
| 2. Stamp DA Form 4160, in duplicate, with the patient identification plate, if available. | P    F |
|---|--------|

*NOTE:* If the patient identification plate is not available, write in the required patient information.

- |  |        |
|--|--------|
| 3. Ensure the patient's personal effects, other than funds and valuables, are inventoried. | P    F |
|--|--------|

*NOTE:* Funds and valuables will be deposited in the patient trust fund. (See task 081-832-1001.)

- |   |  |
|---|--|
| a. Ensure all items are listed on DA Form 4160 and placed in a bag tagged for identification using DD Form 599.<br><br>b. Witness the transaction, if the patient is mentally capable and willing to assist the clothing room clerk with the inventory and sign DA Form 4160. |  |
|---|--|

**Performance Measures**

**Results**

c. Assist the clothing room clerk with the inventory and sign all copies of DA Form 4160, if the patient is unable or unwilling to sign it.

4. Secure the patient's copy of DA Form 4160.

P F

a. Ensure the patient receives a copy of DA Form 4160, if the patient is capable of keeping it secure.

b. Place the patient's copy of DA Form 4160 in the patient's clinical record, if the patient is not capable of securing it.

*NOTE:* The patient clothing room clerk retains the original copy of DA Form 4160.

**REFERENCES:**

*Required*

*Related*

None

AR 40-2

081-832-1003

**PERFORM ADMISSION PROCEDURES ON A PSYCHIATRIC WARD**

**CONDITIONS**

A patient admitted to a psychiatric ward, through the admissions office, has just arrived on the ward. Necessary materials and equipment: hospital and ward regulations and policies, clinical record, patient identification band, SF 509, SF 510, SF 511, and patient identification plate, if available.

**STANDARDS**

Admission procedures are conducted, the patient is oriented to the ward, and the clinical record is prepared IAW local policy.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

- |   |   |   |
|---|---|---|
| 1. Process the patient for admission to the ward.   | P | F |
| a. Verify the patient's identity and greet the patient by--   |   |   |
| (1) Rank and last name, if military.  |   |   |
| (2) Title and last name, if civilian.   |   |   |
| b. Introduce yourself by rank and name.   |   |   |
| c. Explain the role and function of the mental health specialist on the ward.                             |   |   |
| d. Explain each step of the admission procedure to the patient prior to doing it.                         |   |   |
| e. Search the patient for weapons, hazardous items, medications, contraband, or other unauthorized items. |   |   |
| f. Have the patient change into hospital pajamas.   |   |   |
| g. Place a patient identification band on the patient's wrist.  |   |   |

*NOTE:* If the patient has any known allergies, an allergy identification band will also be placed on the patient's wrist.

**Performance Measures**

**Results**

- h. Take the patient's vital signs.
  - (1) Chart the patient's vital signs on SF 511.
  - (2) Notify your supervisor if vital signs are abnormal.
- i. Conduct an admission interview with the patient. (See task 081-832-1023.)
- j. Secure the patient's funds and valuables. (See task 081-832-1001.)
- k. Secure the patient's personal effects. (See task 081-832-1002.)

2. Orient the patient.

P F

a. Allow the patient to read the ward and hospital policies and rules, or read them to him or her if the patient is unable.

*NOTE:* If the patient is incoherent or confused, review the policies and rules with the patient at a later time.

- (1) Explain the policies and rules to the patient, if he or she has any questions.
- (2) Explain fire and safety procedures to be followed.
- (3) Have the patient sign to acknowledge that he or she has read and understands the ward policies and rules.

*NOTE:* This is generally done on a form in the patient's clinical record, IAW local policy.

- b. Explain the schedule and ward activities that occur on a regular basis, to include--
  - (1) Meals.
    - (a) Hours meals are served.
    - (b) Where meals are served.
  - (2) Times for wake-up and lights out.
  - (3) Time and location of therapeutic activities.
    - (a) Group therapy meetings.

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

- (b) Occupational therapy.
  - (c) Recreation therapy.
  - (d) Community meetings.
- (4) Visiting hours.
- c. Introduce the patient to other staff members and patients.
- d. Walk the patient through the areas of the ward that he or she needs to be familiar with, and explain any particular policies regarding those areas.
- (1) Latrine.
  - (2) Sleeping area. Assign the patient to a bed and room.
  - (3) Nurse's station.
  - (4) Dayroom.

3. Prepare and complete the clinical record.

P F

- a. Ensure all forms in the clinical record are stamped with the patient identification plate, if available.

*NOTE:* If the patient identification plate is not available, write in the required patient information.

- b. Record the admission interview IAW local policy.

*NOTE:* This is generally done on SF 509 or SF 510.

- c. Assemble the clinical record by arranging all forms in numerical order as prescribed by the hospital commander.

- d. Ensure all routine or doctor ordered laboratory forms are stamped with the patient identification plate, if available.

4. Inform your supervisor that the admission is complete.

P F

5. Verify that the patient's name is added to the--

P F

**Performance Measures**

**Results**

- a. Ward census roster.
  - b. Patient sign in and out board.
  - c. Admission and Disposition Report.
  - d. Nursing Unit 24-Hour Report.
6. Inform food service of the patient's admission and add the patient's name to the diet roster. P    F

**REFERENCES:**

*Required*

*Related*

None

AR 40-66

**081-832-1004**

**PREPARE A CLASS 1A OR 1B PATIENT FOR AEROMEDICAL EVACUATION**

**CONDITIONS**

A psychiatric patient classified as 1A or 1B is to be transferred to another medical facility by aeromedical evacuation. Necessary materials and equipment: DD Form 600, DD Form 602, SF 510, a folding canvas litter, litter mattress, one pillow, two blankets, one sheet, one pillowcase, two litter straps, and a leather restraint set.

**STANDARDS**

Prepare a class 1A or 1B patient for aeromedical evacuation.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Ensure that the patient has been briefed (either verbally or in writing) on the following:
  - a. Destination hospital.
  - b. Approximate date and time of departure.
  - c. Approximate routing (when known).
  - d. Baggage limitation.

*NOTE:* The standard baggage allowance is 66 pounds per patient.

- e. The necessity for RON (remain overnight), if applicable.

*NOTE:* The amount of information given to the patient is dependent upon the patient's ability to comprehend the information.

2. Prepare the litter.
  - a. Obtain a folding canvas litter.
  - b. Place a litter mattress on the litter.
  - c. Cover the litter mattress with a sheet.
  - d. Place a pillow, with pillowcase, at one end of the litter.

- e. Have one sheet and two blankets available to cover the patient.

*NOTE:* The comfort and safety of the patient, as well as climatic conditions, should be considered.

3. Prepare the patient.

- a. Ensure the patient changes into clean hospital pajamas and slippers.
- b. Ensure the patient has a legible patient identification band on his or her wrist.
- c. Identify the aeromedical classification assigned to the patient.

*NOTE:* The classification is determined by a medical officer.

(1) 1A--severe psychiatric litter patient requiring restraints, sedation, and close supervision at all times.

(2) 1B--psychiatric litter patient of intermediate severity, requiring sedation. Restraints must be available for use.

*NOTE:* This is done in case the patient reacts badly to air travel or begins to endanger himself or herself, others, or the safety of the aircraft.

- d. Check the patient's personal effects to ensure the patient does not have items which may be used to harm himself or herself, or others.

*NOTES:* 1. Items such as matches, neck chains, lighters, or sharp items should be removed from the patient's possession.

2. A physician may give written permission for a patient to wear eyeglasses, rings, and other articles considered necessary for the health and welfare of the patient.

- e. Ensure the patient's valuables are forwarded by registered mail to the destination hospital.
- f. Tag the patient's baggage with DD Form 600. Send it ahead or deliver it with the patient to the departure area.
- g. Ensure the patient receives the prescribed medication.

(1) Read the preflight medication listed on the front of DD Form 602 in the block "Treatment Recommended."

(2) Compare that list to the medication listed on the back of the form in the block "Treatment and Progress Report" to ensure the prescribed medication has been administered.

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(3) Ask qualified medical personnel to administer the medication, if it has not been administered.

(4) Ensure a 3-day supply of medication is provided to the flight nurse for the patient on flights within CONUS.

*NOTE:* A minimum of a 5-day supply of medications is provided for patients traveling from overseas areas to CONUS.

4. Prepare the patient's medical records for transfer.

a. Ensure all available medical records are prepared to accompany the patient, to include the following:

(1) Clinical record.

(2) Health record.

(3) X-rays.

(4) U.S. Field Medical Card.

b. Place the patient's medical records, along with DD Form 602, in an envelope and write the following patient information on the outside of the envelope:

(1) Name.

(2) Rank.

(3) Social security number.

(4) Organization.

(5) Date of departure.

(6) Destination.

5. Place the patient on the litter.

a. Class 1A patient.

(1) If the patient is cooperative, position the patient face-up on the litter and apply mechanical restraints. (See task 081-832-1013.)

(2) If the patient is uncooperative, manually restrain the patient, apply mechanical restraints, and place the patient face-up on the litter. (See tasks 081-832-1012 and 081-832-1013.)

**CAUTION**

Do not restrain the patient to the litter.

- b. Class 1B patient.
  - (1) Position the patient face-up on the litter.
  - (2) Place a set of restraints on the litter.
- 6. Ensure patient comfort and safety.
  - a. Place a sheet and blanket, if required by climatic conditions, over the patient.

*NOTE:* If climatic conditions warrant covering the patient, the mechanical restraints must be placed on the outside of the covers.

- b. Apply litter straps across the patient's chest and thighs.
  - c. Remain with the patient until properly relieved of responsibility for the patient.
- 7. Relinquish responsibility for the patient to the flight nurse.
  - a. Deliver the patient to the designated departure area.
  - b. Provide the flight nurse with the medications and medical records.
  - c. Report to the flight nurse on the patient's current condition.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Ensure that the patient has been briefed verbally or in writing.	P    F
2. Prepare the litter.	P    F
3. Prepare the patient.	P    F
4. Prepare the patient's medical records for transfer.	P    F

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- |   |   |   |
|---|---|---|
| 5. Place the patient on the litter.                               | P | F |
| 6. Ensure patient comfort and safety.                             | P | F |
| 7. Relinquish responsibility for the patient to the flight nurse. | P | F |

**REFERENCES:**

***Required***

None

***Related***

AR 40-535

081-832-1005

**PREPARE A CLASS 1C PATIENT FOR AEROMEDICAL EVACUATION**

**CONDITIONS**

A psychiatric patient is classified as 1C for aeromedical evacuation. The patient has an appropriate service uniform available. Necessary materials: DD Form 602 and DD Form 600.

**STANDARDS**

Prepare a class 1C patient for aeromedical evacuation.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

*NOTE:* Class 1C is designated for psychiatric ambulatory patients of moderate severity who are cooperative and have proven to be reliable under observation.

- |   |            |
|---|------------|
| <p>1. Ensure that the patient has been briefed (either verbally or in writing) on the following:</p> <ul style="list-style-type: none"> <li>a. Destination hospital.</li> <li>b. Approximate date and time of departure.</li> <li>c. Approximate routing (when known).</li> <li>d. Baggage limitation.</li> </ul> | <p>P F</p> |
|---|------------|

*NOTE:* The standard baggage allowance is 66 pounds per patient.

- |  |            |
|--|------------|
| <ul style="list-style-type: none"> <li>e. The necessity for RON (remain overnight), if applicable.</li> </ul> <p>2. Ensure the patient receives the prescribed medication, if applicable.</p> <ul style="list-style-type: none"> <li>a. Read the medication listed on the front of DD Form 602 in the block "Treatment Recommended."</li> <li>b. Compare that list to the medication listed on the back of the form in the block "Treatment and Progress Report" to ensure the prescribed medication has been administered.</li> </ul> | <p>P F</p> |
|--|------------|

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

c. Ask qualified medical personnel to administer the preflight medication, if necessary.

d. Ensure a 3-day supply of patient medications is provided to the flight nurse for the patient on flights within CONUS.

*NOTE:* A minimum of a 5-day supply is prepared if the patient is traveling from overseas to CONUS.

3. Check to see that the patient has a legible patient identification band on his or her wrist. P F

4. Check the patient's baggage for hazardous items and contraband. P F

5. Ensure the patient's baggage is tagged with DD Form 600 and accompanies the patient. P F

6. Encourage the patient to send funds and valuables by registered mail. P F

7. Have the patient change into his or her service uniform. P F

8. Prepare the patient's medical records for transfer. P F

a. Ensure all available medical records are prepared to accompany the patient, to include the following:

(1) Clinical record.

(2) Health Record.

(3) X-rays.

(4) U.S. Field Medical Card.

b. Place the patient's medical records, along with DD Form 602, in an envelope and write the following information on the outside of the envelope:

(1) Name.

(2) Rank.

(3) SSN.

<b>Performance Measures</b>	<b>Results</b>
(4) Organization.	
(5) Date of departure.	
(6) Destination.	
9. Escort the patient to the aeromedical evacuation departure area.	P F
10. Provide the aeromedical evacuation clerk with the patient's medical records and medications.	P F

*NOTE:* Local policy may require that the patient be escorted to the flight and that the medical records and medications be turned over to the flight nurse.

<b>REFERENCES:</b>	<i>Required</i>	<i>Related</i>
	None	AR 40-535

081-832-1027

**PERFORM DISCHARGE PROCEDURES ON A PSYCHIATRIC WARD**

**CONDITIONS**

A physician has written a discharge order for a psychiatric patient. Necessary materials: clinical record, DA Form 4029, and DA Form 4700.

**STANDARDS**

Perform all necessary steps to discharge a patient.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

- |  |   |   |
|--|---|---|
| 1. Prepare the patient for discharge from the hospital.          | P | F |
| a. Inform the patient of impending discharge.                    |   |   |
| b. Assist the patient in packing personal effects, if necessary. |   |   |

*NOTE:* Ensure the patient takes any other personal items not kept at bedside such as OT projects and razor.

- |  |   |   |
|--|---|---|
| c. Assist the patient in clearing the hospital using DA Form 4029.           |   |   |
| (1) Patient Trust Fund.  |   |   |
| (2) Baggage Room.  |   |   |
| (3) Patient Administration.  |   |   |
| (4) Medical Holding Company, if applicable.                                  |   |   |
| (5) Ensure the patient receives prescriptions for any discharge medications. |   |   |
| 2. Complete the discharge paperwork on the patient.                          | P | F |
| a. Write a discharge note which includes:                                    |   |   |
| (1) Date and time of discharge.  |   |   |

**Performance Measures**

**Results**

- (2) Manner of discharge.
  - (a) Discharge destination.
  - (b) How and with whom the patient leaves the hospital.
- (3) Status of the patient at the time of discharge.
  - (a) Current problems.
  - (b) Resolved issues and problems.
- (4) Patient teaching performed regarding--
  - (a) Discharge follow-up.
  - (b) Medications.
  - (c) Dietary or activity restrictions.
- (5) The patient's comprehension of the instructions given.

*NOTE:* The discharge note is generally recorded on the SF 509 or SF 510 or IAW local policy.

- b. Assist in the completion of the patient discharge plan.

*NOTE:* This may be done with assistance from the nurse on an overprinted DA Form 4700, completed in duplicate.

- (1) Document the preparation of the patient for discharge.
  - (a) Instructions given to the patient.
  - (b) Follow-up appointments and medication.
- (2) Write the information in a language understood by the patient.
- (3) Sign the form and have the patient sign it to acknowledge receipt of the information.
- (4) Place the original copy in the clinical record.

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

- (5) Give the patient the duplicate copy to take with him or her.
- 3. Complete the patient's discharge. P    F
  - a. Assist the patient in obtaining transportation, if necessary.
  - b. Allow the patient time to say good-byes to the staff and other patients.
  - c. Verify the patient's name is placed on the Nursing Unit 24-Hour Report.
  - d. Delete the patient's name from the Admission and Disposition Report, the ward census roster, and the patient sign in and out board.
  - e. Notify food service of the patient's discharge.

**REFERENCES:**

*Required*

*Related*

None

AR 40-407

081-832-1006

**MONITOR A PATIENT'S USE OF A POTENTIALLY DANGEROUS ITEM**

**CONDITIONS**

A psychiatric patient needs to use an item that is potentially dangerous. Necessary materials: logbook.

**STANDARDS**

Monitor a patient's use of a potentially dangerous item in a specified area without causing injury to the patient or other personnel. Ensure that the item is turned in immediately after use.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

- |  |        |
|--|--------|
| 1. Explain to the patient the procedures to be followed.                                   | P    F |
| a. Authorized times to sign items in and out.  |        |
| b. Utilization of the item is to be in the presence of a staff member.                     |        |
| c. A staff member documents items signed out and in by logging the following:              |        |
| (1) The name of the patient using the item.  |        |
| (2) The type of item to be used.   |        |
| (3) The time and date the item was signed out and in.                                      |        |
| (4) The staff member's signature.  |        |
| 2. Inspect the item to ensure that it is complete and operable before the patient uses it. | P    F |
| 3. Explain and demonstrate proper use of the item, if necessary.                           | P    F |
| 4. Constantly observe the patient's use of the item.                                       | P    F |
| a. Ensure that the patient uses the item in a safe manner.                                 |        |
| b. Intervene if the patient begins to use the item in an unsafe manner.                    |        |

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

5. Account for the item.

P F

a. Ensure the patient returns it complete and cleaned.

b. Log the item in as having been returned by the patient.

**REFERENCES:** None

081-832-1007

**PERFORM LINE OF SIGHT OBSERVATION OF A PSYCHIATRIC PATIENT****CONDITIONS**

A psychiatric patient has been assessed as needing close observation and the doctor has ordered line of sight observation. Necessary materials: clinical record.

**STANDARDS**

Observe a patient placed on line of sight observation. Take all reasonable steps to protect the patient and others from harm.

**TRAINING AND EVALUATION***Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Inform the patient that he or she is on line of sight observation.	P    F
2. Explain to the patient what line of sight observation is.	P    F
a. The patient must remain within view of the assigned staff member at all times.	
b. The patient's behavior will be closely monitored.	
3. Explain to the patient the behaviors that caused placement on line of sight observation.	P    F
4. Explain to the patient the behavior that must be exhibited to be taken off line of sight observation.	P    F
a. Willingness to follow ward and hospital policies and rules.	
b. Ability to demonstrate self-control, if the patient has a history of aggressive or self-destructive behavior.	
5. Do steps 1 through 4 in order.	P    F
6. Observe the patient's behavior.	P    F
a. Keep the patient within view at all times.	
b. Intervene if the patient requires redirection.	

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

(1) Remove potentially dangerous objects from within reach of the patient, if necessary.

(2) Allow the patient to express his or her thoughts and feelings.

(3) Set limits by clearly stating behaviors expected of the patient.

c. Obtain assistance if the patient does not respond to verbal intervention.

*NOTE:* Manual and/or mechanical restraint may be necessary depending on the situation. (See tasks 081-832-1012 and 081-832-1013.)

d. Inform the patient when his or her behavior is appropriate.

(1) Give the patient reassurance and support for specific positive behaviors demonstrated.

(2) Encourage the patient to continue his or her positive behavior.

7. Terminate line of sight observation only when properly relieved.

P F

*NOTE:* Line of sight observation should be assigned on a rotating basis at 2 hour intervals. This will ensure alertness of staff and quality of observation.

a. Brief the relief staff member regarding the reason the patient was placed on line of sight observation.

b. Describe the patient's current behavior to the relief staff member.

8. Document the patient's behavior and conversation IAW local policy.

P F

*NOTE:* Some wards require that a checklist be initialed by the assigned staff member at certain intervals throughout the watch. This is in addition to documentation in the clinical record.

9. Make recommendations to the nurse for the patient's removal from line of sight observation, if applicable, taking into consideration--

P F

a. The patient's observed behavior over a period of time.

b. The patient's previous behavior patterns.

**REFERENCES:** None



**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

- b. Remove hazardous items within reach of the patient, if applicable.
- c. Prevent the patient from doing bodily harm to himself or herself or others.
- d. Inform the patient when his or her behavior is appropriate.
  - (1) Give the patient reassurance and support.
  - (2) Encourage the patient to continue this behavior.

3. Terminate 1:1 observation only when properly relieved.

P F

*NOTE:* The 1:1 observation should be assigned on a rotating basis at 2 hour intervals. This will ensure alertness of staff and quality of observation.

- a. Brief the relief staff member as to why the patient was placed on 1:1 observation.
- b. Describe the patient's current behavior to the relief staff member.

4. Document the patient's behavior and conversation IAW local policy.

P F

*NOTE:* Some wards require that a checklist be initialed at certain intervals throughout the watch. This is in addition to documentation in the clinical record.

5. Make recommendations to the nurse for removal of the patient from 1:1 observation, if applicable, taking into consideration--

P F

- a. The patient's observed behavior over a period of time.
- b. The patient's previous behavior patterns.

**REFERENCES:** None

081-832-1009

ACCOUNT FOR THE LOCATION OF PSYCHIATRIC PATIENTS

CONDITIONS

Psychiatric patients, assigned to the ward, are scheduled for activities and appointments off of the ward. Necessary materials: ward census roster, Admission and Disposition Report, and patient sign in and out board.

STANDARDS

Account for the location of patients assigned to the ward with 100% accuracy.

TRAINING AND EVALUATION

*Evaluation Guide*

Performance Measures

Results

- |   |                                  |
|---|----------------------------------|
| <ol style="list-style-type: none"> <li>1. Verify the accuracy of the ward census roster.             <ol style="list-style-type: none"> <li>a. Compare the ward census roster to the daily Admission and Disposition Report.</li> <li>b. Add the names of newly admitted patients to the ward census roster, if necessary.</li> <li>c. Delete the names of discharged patients from the ward census roster, if necessary.</li> </ol> </li> <li>2. Update the patient sign in and out board by comparing it to the ward census roster.             <ol style="list-style-type: none"> <li>a. Add to the patient sign in and out board the names of patients who have been admitted to the ward.</li> <li>b. Delete from the patient sign in and out board the names of patients who have been discharged from the ward.</li> </ol> </li> <li>3. Account for patients on the ward.</li> </ol> | <p>P F</p> <p>P F</p> <p>P F</p> |
|---|----------------------------------|

*NOTE:* Accountability of all patients assigned to a psychiatric ward should be done at irregular periods throughout each shift, IAW local policy.

- a. Count the number of the patients in the ward area.
- b. Compare the ward census roster to the number and names of the patients currently on the ward.

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

4. Account for the patients who are not present on the ward.

P F

a. Check the patient sign in and out board for the location of patients not present on the ward.

b. Check with other staff members for knowledge regarding the whereabouts of any patients not accounted for and verify the information.

*NOTE:* If the patient is accounted for as being off the ward with permission, but forgot to sign out, the mental health specialist will sign him or her out on the patient sign in and out board.

c. Verify the names of the patients not accounted for.

d. Inform the immediate supervisor of the names of the patients not accounted for, if applicable.

**REFERENCES:** None

081-832-1010

**ESCORT A PSYCHIATRIC PATIENT**

**CONDITIONS**

A psychiatric patient is scheduled to leave the ward area with a staff escort to go to a specific destination. Necessary materials: patient sign in and out board and clinical record.

**STANDARDS**

Escort a psychiatric patient to and from a specific destination. Perform all steps in order.

**TRAINING AND EVALUATION**

*Evaluation Guide*

**Performance Measures**

**Results**

- |  |               |
|--|---------------|
| <ol style="list-style-type: none"> <li>1. Prepare for departure from the ward.             <ol style="list-style-type: none"> <li>a. Familiarize yourself with the patient's history.</li> <li>b. Obtain the following information:                 <ol style="list-style-type: none"> <li>(1) Scheduled time for the appointment or activity.</li> <li>(2) Destination.</li> <li>(3) Mode of transportation to be used, if necessary.</li> <li>(4) Necessary items to accompany the patient, such as health and clinical records.</li> <li>(5) When the next routine dose of medication should occur.</li> </ol> </li> <li>c. Explain to the patient--                 <ol style="list-style-type: none"> <li>(1) When and where he or she is going.</li> <li>(2) The procedure to be followed.</li> </ol> </li> <li>d. Sign the patient out on the patient sign in and out board.</li> </ol> </li> </ol> | <p>P    F</p> |
|--|---------------|

## STP 8-91X14-SM-TG

### Performance Measures

### Results

*NOTES:* 1. When escorting a group of patients, identify and count the patients prior to leaving the ward and prepare a patient list containing the names of all patients being escorted. Also, ensure the patients are signed out on the patient sign in and out board.

2. One mental health specialist escorting four patients is considered optimal coverage. The staff-patient ratio should also be based on the number of patients being escorted, the type of activity, and the condition of the patients being escorted.

2. Depart the ward for the destination.

P F

a. Utilize only approved modes of transportation.

*NOTE:* A patient is not to be transported in privately owned vehicles.

b. Ensure safety of the patient at all times.

c. Take the patient directly to the destination.

*NOTE:* When escorting a group of patients, count the patients at intervals while en route.

3. Remain with the patient while at the destination.

P F

*NOTE:* If a patient is scheduled for a medical procedure or an appointment that does not allow for the specialist's presence, remain in the immediate area and ensure the receiving attendant knows to release the patient only to the specialist.

a. Observe the patient closely.

b. Intervene if the patient--

(1) Exhibits inappropriate behavior.

(2) Endangers self or others.

(3) Attempts to elope.

*NOTE:* When escorting a group of patients, count the patients periodically.

4. Return the patient to the ward following the guidelines in step 2.

P F

5. Sign the patient in on the patient sign in and out board.

P F

*NOTE:* If escorting a group of patients, count all patients upon return to the ward and ensure they are signed in on the patient sign in and out board.

**Performance Measures**

**Results**

- |  |   |   |
|--|---|---|
| 6. Search the patient upon return to the ward for hazardous items or contraband. | P | F |
| 7. Record any significant patient behavior in the clinical record.               | P | F |
| 8. Do all steps in order.  | P | F |

**REFERENCES:** None

**081-832-1028**

**CONDUCT AN ADMISSION INTERVIEW WITH A PSYCHIATRIC PATIENT**

**CONDITIONS**

A patient has been admitted through the admissions office to the psychiatric ward. The patient has been searched and admitted by the mental health specialist, and vital signs have been taken. Necessary materials: clinical record.

**STANDARDS**

Conduct the admission interview and document the information. Perform steps 1 through 5 in order.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Provide a comfortable, secure atmosphere for the interview.

a. Ensure the physical setting allows for some privacy.

*NOTE:* Generally a treatment room or office area is used.

b. Allow the patient to talk freely and frankly.

c. Avoid unnecessary interruptions.

d. Allow for a comfortable distance between the patient and yourself, to avoid making the patient feel threatened.

*NOTE:* This will vary depending on the type of patient being interviewed.

2. Explain the purpose of the interview to the patient.

3. Conduct the admission interview in accordance with the admission interview objectives.

a. Obtain information with which to assess the patient's current level of functioning.

b. Establish a therapeutic relationship with the patient. (See task 081-832-1023.)

c. Obtain information to assist in identification of the patient's problem and formulation of a treatment plan.

4. Obtain identifying data.

- a. Verify the patient's basic data.
  - (1) Name.
  - (2) Rank.
  - (3) Social security number.
  - (4) Sex.
  - (5) Age.
  - (6) Race.
  - (7) Marital status.
  - (8) Military status (active duty, retired, or reservist).
  - (9) Eye color.
  - (10) Hair color and length.
- b. Ask the patient about any known allergies or distinguishing features, such as scars or tattoos.
- c. Measure and weigh the patient.

*NOTE:* Also, check the patient's health record or ID card for this information, if available.

5. Obtain information regarding how the patient was admitted to the ward.
  - a. Identify whether the patient was admitted to the ward ambulatory, in a wheelchair, or on a litter.
  - b. Identify the type of admission.
    - (1) Transfer--from another ward.
    - (2) Routine--processed through the admissions office.
    - (3) Direct--bypassed the admissions office.
6. Obtain current medical information.
  - a. Ask the patient about any physical problems he or she is currently experiencing or receiving treatment for.

## STP 8-91X14-SM-TG

- b. Ask the patient about any medications he or she is currently taking.
  - (1) Prescribed and over-the-counter medications.
  - (2) The amount and frequency of the medications he or she is currently taking.
- 7. Obtain a history of the patient's present illness.
  - a. Identify the chief complaint by asking the patient about the following:
    - (1) Why he or she thinks he or she was admitted to the ward.
    - (2) What events or behavior led up to his or her hospitalization.
    - (3) What symptoms he or she was experiencing.
      - (a) Suicidal or homicidal thoughts.
      - (b) Psychotic symptoms, such as hallucinations or delusions.
    - (4) When the symptoms or behaviors first began.
  - b. Assess the level of functioning the patient was able to maintain prior to his or her hospitalization.
    - (1) Work performance.
    - (2) Ability to perform activities of daily living (ADL).
    - (3) Ability to interact with others--family, friends, and coworkers.
  - c. Ask what the patient's feelings are about his or her illness and being in the hospital.
  - d. Ask the patient whether he or she has used alcohol or illicit and/or nonprescribed drugs within the past 72 hours.
    - (1) Date and time the substance was ingested.
    - (2) Type and amount of substance ingested.
- 8. Obtain a history of previous psychiatric illness.
  - a. Ask the patient if he or she has ever received psychiatric treatment in the past, and obtain the following information, if applicable:
    - (1) Outpatient or inpatient psychiatric treatment and where.

- (2) Alcohol or drug detoxification or rehabilitation.
  - (3) Previous diagnosis, if known.
  - (4) Psychiatric medications prescribed, if known.
  - b. Ask the patient about previous suicidal ideations or attempts.
    - (1) Have the patient describe ideations.
    - (2) Obtain information regarding suicide attempts.
      - (a) How.
      - (b) When.
      - (c) Where.
      - (d) Outcome--whether medical treatment was required or any psychiatric evaluation or treatment was done at the time.
  9. Observe the patient's behavior and appearance throughout the interview, to include the following:
    - a. Hygiene and grooming.
    - b. Facial expression.
    - c. Eye contact.
    - d. Motor activity.
    - e. Posture.
    - f. Mannerisms and gestures.
    - g. Verbal and nonverbal communication.
  10. Document in the clinical record your observations and the information obtained from the patient.
- NOTE:* Documentation will be done on SF 509 or SF 510 IAW local policy.
11. Report to your supervisor any information obtained that causes concern for the safety of the patient or others.

*Evaluation Preparation*

*Setup:* For training and evaluation, have another soldier act as the patient. Coach the patient on the required actions to demonstrate and remarks to make.

*Brief soldier:* Tell the soldier to conduct an admission interview with the simulated patient. Ask the soldier to describe and explain his actions.

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Provide a comfortable, secure atmosphere for the interview.	P	F
2. Explain the purpose of the interview to the patient.	P	F
3. Conduct the admission interview IAW interview objectives.	P	F
4. Obtain identifying data.	P	F
5. Obtain information regarding how the patient was admitted to the ward.	P	F
6. Do steps 1 through 5 in order.	P	F
7. Obtain current medical information.	P	F
8. Obtain a history of the patient's present illness.	P	F
9. Obtain a history of the patient's previous psychiatric illness.	P	F
10. Observe the patient's behavior and appearance throughout the interview.	P	F
11. Document in the clinical record, observations and the information obtained from the patient.	P	F
12. Report to your supervisor any information obtained that causes concern about safety for the patient or others.	P	F

**REFERENCES:**

*Required*

*Related*

None

AR 40-407

081-832-1029

## ASSIST IN ASSESSMENT OF A PSYCHIATRIC PATIENT

### CONDITIONS

A patient has been admitted and oriented to the psychiatric ward. A professional nurse is available to assist the mental health specialist. Necessary materials: clinical record.

### STANDARDS

Assess the patient's physical state, cognitive functioning, interpersonal relations, affective state, adaptation skills, and self-concept. Document the information accurately.

### TRAINING AND EVALUATION

#### *Training Information Outline*

*NOTE:* Assessment is the first step of the nursing process with the primary purpose being to identify the patient's problems.

1. Collect data to assess the patient's physical state.
  - a. Activities of daily living.
    - (1) Identify problems associated with the patient's diet, such as weight, appetite, fluid intake, and poor nutrition.
    - (2) Identify problems with elimination, such as constipation, diarrhea, or incontinence.
    - (3) Identify sleep and rest difficulties, to include quality of sleep, amount of sleep, and difficulties falling to sleep and staying asleep.
    - (4) Identify activity level problems associated with the types of exercise and activities the patient is involved in.
  - b. Identify any personal appearance problems, indicated by the patient's personal hygiene, grooming, dress, and posture.
  - c. Identify any physical health problems utilizing the findings of the patient's physical exam, lab results, and health history.
2. Collect data to assess the patient's cognitive functioning.
  - a. Identify any problems with sensorium and perception.

## STP 8-91X14-SM-TG

- (1) Hallucinations.
- (2) Illusions.
- (3) Delusions.
- b. Identify any problems with memory.
  - (1) Recent memory.
  - (2) Remote memory.
- c. Identify any problems with orientation to--
  - (1) Time.
  - (2) Place.
  - (3) Person.
- d. Identify any problems with judgment and insight in relation to--
  - (1) Social norms.
  - (2) Money management.
  - (3) Future plans.
  - (4) The patient's awareness of his or her problems.
- e. Identify any problems with communication due to--
  - (1) Abnormal thought processes such as loose associations or flight of ideas.
  - (2) Amount and content of verbalization.
3. Collect data to assess the patient's interpersonal relations.
  - a. His or her ability to interact with others.
    - (1) At work and/or school.
    - (2) At home.
    - (3) Within the community.

- b. Examine the patient's relationships with others in terms of--
  - (1) Trust vs mistrust.
  - (2) Dependence vs independence.
  - (3) Compatibility vs conflict.
- 4. Collect data to assess the patient's affective state.
  - a. Identify any abnormalities in expression of mood and affect.
  - b. Identify any difficulties in expressing feelings.
- 5. Collect data to assess the patient's self-concept.
  - a. Identify any problems related to body image, sexuality, and spirituality.
  - b. Identify any problems related to the patient's self-esteem and feelings of self-worth.
- 6. Collect data to assess the patient's adaptation skills.
  - a. Identify the patient's previous and current coping skills.
  - b. Identify any factors which interfere with the patient's ability to adapt to change.
- 7. Document the data collected.
  - a. Assist in formulating the patient problem list, based on data collected.
  - b. Assist in completing the assessment section of DA Form 3888.
  - c. Report and record significant observations and findings.

*NOTE:* Documentation will be done IAW local policy.

### ***Evaluation Preparation***

*Setup:* For training and evaluation, have another soldier act as the patient.

*Brief soldier:* Tell the soldier to assess the types of problems the patient is having regarding physical state, cognitive functioning, interpersonal relations, affective state, adaptation skills, and self-concept.

*Evaluation Guide*

**Performance Measures**

**Results**

1. Collect data to assess the patient's physical state.	P	F
2. Collect data to assess the patient's cognitive functioning.	P	F
3. Collect data to assess the patient's interpersonal relations.	P	F
4. Collect data to assess the patient's affective state.	P	F
5. Collect data to assess the patient's self-concept.	P	F
6. Collect data to assess the patient's adaptation skills.	P	F
7. Document the data collected.	P	F

**REFERENCES:**

*Required*

*Related*

None

AR 40-407

081-832-1030

**ASSIST IN THE IDENTIFICATION OF TREATMENT GOALS AND INTERVENTIONS**

**CONDITIONS**

A psychiatric patient has been assessed and a problem list identified. A nurse is available for assistance. Necessary materials: clinical record.

**STANDARDS**

Provide assistance in identifying realistic, specific, and measurable goals that are related to the patient's identified problems.

**TRAINING AND EVALUATION**

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Involve the patient in planning the treatment goals, if possible.	P F
<i>NOTE:</i> This will depend on the degree of the patient's impairment and insight regarding his or her illness.	
2. Assist in identifying treatment goals which are--	P F
a. Realistic, based on the individual patient's current needs, problems, and functioning.	
b. Clearly stated in behavioral terms and can be measured in terms of expected outcome.	
3. Establish a specific time frame for the patient to achieve the goals.	P F
<i>NOTE:</i> Goals are usually divided into two categories--short and long term goals. Short term goals refer to sequential steps necessary for achievement of the broader long term goal.	
4. Assist in planning the interventions.	P F
a. Identify specific therapeutic approaches which will assist the patient in achieving the treatment goals.	

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

b. State the intervention in specific terms so that other treatment team members can carry out the intervention effectively, by stating--

- (1) What will be done.
- (2) How it will be done.
- (3) Where it will be done.
- (4) Who will do it.
- (5) How often it will be done.

c. Take into consideration the personnel and resources available, as well as the individual patient's strengths and weaknesses.

5. Document the goals and interventions.

P F

*NOTE:* Frequency, where, and by whom this information is documented will be IAW local policy. Generally it will be done on DA Form 3888.

**REFERENCES:**

***Required***

***Related***

None

AR 40-407  
DA Pam 40-5

081-832-1031

**ASSESS A PSYCHIATRIC PATIENT'S SUICIDAL POTENTIAL**

**CONDITIONS**

A psychiatric patient is expressing suicidal ideation (verbally or behaviorally). Necessary materials: clinical record.

**STANDARDS**

Conduct an assessment of the patient's suicidal potential. Perform interventions to prevent the patient from harming himself or herself.

**TRAINING AND EVALUATION**

*Training Information Outline*

1. Recognize the warning signs of self-destructive behavior.
  - a. The patient may express direct or indirect verbal warnings of suicide intent by making remarks such as--
    - (1) "I can't take it anymore."
    - (2) "I won't be seeing you again."
    - (3) "I wish I were dead."
  - b. The patient may demonstrate behavioral signs of suicide intent by--
    - (1) Making or changing a will.
    - (2) Giving away valuables or prized possessions.
    - (3) Organizing personal or business matters as if planning to be away for an extended period.
    - (4) Suddenly recovering from a severe depression.
  - c. The patient may demonstrate or express feelings of--
    - (1) Helplessness--inability to change or alter the situation.
    - (2) Guilt--responsible for others' or their own dilemma.

## STP 8-91X14-SM-TG

(3) Rage and/or agitation towards others, but directed towards himself or herself.

2. Assess the patient's risk for suicide.

a. Question the patient about his or her suicidal intent.

*NOTE:* Be direct and specific when questioning the patient.

(1) Does the patient have a specific plan or thoughts of harming himself or herself? If so, attempt to get the specific details of the plan--time, place, and method.

(2) Does the patient have a history of previous suicide attempts? If so, when, where, and what method was used?

b. Determine the risk factors that increase the patient's likelihood for suicide.

(1) Age. Persons 15 to 24 years of age and over age 50 are at higher risk.

(2) Sex. Males are more likely to commit suicide.

(3) Physical illness. Persons suffering from physical illness, especially chronic or terminal illness, are at higher risk.

(4) Alcohol or drug abuse. It decreases impulse control and places the patient at higher risk.

(5) Psychotic symptoms. Persons suffering from hallucinations and delusions are at higher risk.

3. Perform technician interventions.

a. Protect the patient from himself or herself.

(1) Directly intervene if the patient attempts to harm himself or herself.

(a) Perform immediate first aid.

(b) Call for assistance, if necessary.

(2) Take necessary precautions.

(a) Search the patient and belongings for hazardous items.

*NOTE:* Simply asking the patient if he or she has a hazardous item is not sufficient as the patient may conceal it for later use.

(b) Ensure cleaning equipment and supplies are stored in a locked area.

- (c) Monitor the patient's use of potentially dangerous items. (See task 081-832-1006.)
- (d) Check the ward for potential hazards such as exposed pipes, drapery cords, glass fixtures, and extension cords.
- b. Perform 1:1 or line of sight observation, if ordered by the doctor. (See tasks 081-832-1007 and 081-832-1008.)
- c. Utilize crisis intervention steps.
  - (1) Assess the patient, focusing on his or her immediate problem and/or situation.
    - (a) Explore any precipitating events or current stressors.
    - (b) Determine the patient's perception of his or her current situation.
    - (c) Assess the factors affecting the patient's ability to cope.
    - (d) Determine what kinds of outside support the patient has (family, friends, clergy).
    - (e) Assess the patient's individual strengths and coping skills.
  - (2) Plan the intervention.
    - (a) Determine how the crisis has affected the patient's life (work, family, daily activities).
    - (b) Explore additional environmental and social support available to the patient.
  - (3) Implement the intervention.
    - (a) Define the problem as seen by the mental health specialist and reflect this back to the patient.
    - (b) Encourage the patient to express his or her feelings and thoughts.
    - (c) Discuss and offer alternative coping skills and problem solving behaviors.
    - (d) Encourage utilization of other resources for support.
    - (e) Test or rehearse new problem solving approaches.
- 4. Record and report observations of the patient.
  - a. Promptly report specific patient conversation and behavior to the nurse.

**STP 8-91X14-SM-TG**

- b. Document the patient's specific behavior, appearance, and conversation accurately and promptly.

*NOTE:* This will be done on SF 509 or SF 510 IAW local policy.

***Evaluation Preparation***

*Setup:* For training and evaluation, have another soldier act as a suicidal psychiatric patient and demonstrate the signs and symptoms selected. Coach the soldier on how to answer questions asked by the mental health specialist.

*Brief soldier:* Tell the mental health specialist to observe the simulated patient for warning signs of self-destructive behavior, assess the patient's risk for suicide, and intervene accordingly. Ask the soldier to describe and explain his or her actions.

***Evaluation Guide***

<b>Performance Measures</b>	<b>Results</b>	
1. Recognize the warning signs of self-destructive behavior.	P	F
2. Assess the patient's risk for suicide.	P	F
3. Perform technician interventions.	P	F
4. Record and report observations of the patient.	P	F

**REFERENCES:** None

081-832-1020

**DETERMINE PATIENT CARE ASSIGNMENTS**

**CONDITIONS**

As shift leader, you have been designated to assign patient care duties to mental health specialists on duty. DA Form 4677 is available. Necessary materials: DA Form 3888 and DA Form 4015.

**STANDARDS**

Assign patient care needs to available mental health specialists based on the patient's Nursing Assessment and Care Plan and the ward schedule.

**TRAINING AND EVALUATION**

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>
1. Review the patient's DA Form 3888.	P F
a. Identify the patient's problems.	
b. Review the short and long range goals.	
c. Review the nursing history.	
2. Review the patient's DA Form 4677.	P F
a. The type of interventions or care to be performed.	
b. The frequency and time the interventions or care are to be performed.	
3. Complete DA Form 4015.	P F
a. Assign patient care duties to a mental health specialist, taking into consideration--	
(1) The individual needs of the patient.	
(2) The skills of the mental health specialist.	
(3) Escort duties.	
(4) Admission and discharge duties.	

**STP 8-91X14-SM-TG**

**Performance Measures**

**Results**

- (5) Mealtime supervision.
  - (6) Number of patients in seclusion or restraints.
  - (7) Number of patients on special watch.
  - (8) Scheduled patient treatments and activities.
  - (9) Staff meetings and conferences.
- b. Indicate the time and frequency the care or intervention is to be performed, if applicable.
- c. Indicate which patient charting the mental health specialist is responsible for.
4. Review DA Form 4015 with the mental health specialist. P F
- a. Ensure the mental health specialist understands the assignment.
  - b. Tell the mental health specialist to review the patient's problems, goals, and history on DA Forms 3888 and 4677, if not familiar with the plan of care for the patient.
5. Conduct a review of the patient care charting when completed and provide feedback to the specialist. P F

**REFERENCES:**

*Required*

*Related*

None

AR 40-407

081-832-1021

**COFACILITATE A GROUP THERAPY SESSION**

**CONDITIONS**

A qualified group therapist and 5 to 10 psychiatric patients are seated in a circle in a quiet area or in a room. The group is an open group scheduled for 1 hour, three times a week. Necessary materials: clinical records.

**STANDARDS**

Conduct the group therapy session within the stated guidelines and objectives.

**TRAINING AND EVALUATION**

*Evaluation Guide*

<b>Performance Measures</b>	<b>Results</b>	
1. Start the group at the scheduled time.	P	F
2. Ensure that new group members are introduced to the group.	P	F
3. Explain the ground rules of the group to include--	P	F
a. The start and stop times of the group.		
b. The procedures for speaking--one person speaks at a time.		
c. Participation expectations.		
(1) Physical violence is not allowed.		
(2) Verbal expression of feelings is encouraged.		
d. Confidentiality issues of the group.		
4. Explain the purposes of the group therapy session.	P	F
a. To increase self-awareness.		
b. To improve interpersonal relationships.		
c. To make behavioral changes.		

## STP 8-91X14-SM-TG

### Performance Measures

### Results

5. Perform leadership tasks during the group session.

P F

a. Observe the group process.

(1) Summarize and make verbal comments on the group process.

(2) Assess the level of anxiety of the group members.

(a) Encourage examination of the cause(s) of the anxiety and the group members' response to it.

(b) Encourage group members to deal with the anxiety in a constructive manner.

b. Establish direction for the group.

(1) Clarify the goals of the group.

(2) Redirect the group members toward the purpose of the group, as necessary.

c. Act as a role model for appropriate behavior.

(1) Listen attentively.

(2) Respond honestly.

(3) Give support and encouragement to other group members.

(4) Confront group members who demonstrate unhealthy behavior such as monopolizing the group, putting oneself down, or manipulation of other group members.

d. Direct the group members towards closure of the group session.

*NOTE:* This is done 5 to 10 minutes prior to the scheduled time for the group to end.

(1) If a group issue is not able to be completed, reassure the group members that it will be continued at the next session, if appropriate.

(2) Summarize the content of the group session.

(3) End the group session on time.

**Performance Measures**

**Results**

*NOTE:* If a group member appears distraught or upset at the end of the group session, one of the group facilitators should remain with the patient to ensure his or her safety.

- |   |   |   |
|---|---|---|
| 6. Document the group therapy session in the clinical records IAW local policy.               | P | F |
| a. Document each individual's interaction in the group session.                               |   |   |
| b. Document incidents or behavior demonstrated by each group member during the group session. |   |   |

**REFERENCES:** None



FIELD EXPEDIENT SQUAD BOOK		SHEET	OF											
For use of this form, see AR 350-37; the proponent agency is DCSOPS														
USER APPLICATION	SOLDIER'S NAME													
TASK NUMBER AND SHORT TITLE	STATUS													
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-831-0044, Apply Pneumatic Splint														
081-831-0033, Initiate Field Medical Card														
081-831-0035, Manage Convulsive Patient														
081-831-0038, Treat Heat Injury														
081-831-0039, Treat Cold Injury														
081-832-0062, Collect Collateral Information														
081-832-0063, Conduct Info Gather Interview														
081-832-0011, Conduct Collateral Interview														
081-832-0013, Present Case for Supervision														
081-832-0005, Assess Client's Mental Status														
081-832-0006, Assess Client Social Function														
081-832-0064, Assess Client Psychopathology														
081-832-0023, Determine Homicidal Potential														

EDITION OF DEC 82 TO BE USED

DA FORM 5165-R, SEP 85

<b>FIELD EXPEDIENT SQUAD BOOK</b>		SHEET	OF											
For use of this form, see AR 350-37; the proponent agency is DCSOPS														
USER APPLICATION	SOLDIER'S NAME													
TASK NUMBER AND SHORT TITLE	STATUS													
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	NO-GO	
081-832-0026, Determine Suicidal Potential														
081-832-0065, Assess Substance Use/Abuse														
081-832-0007, Conduct Referral Service														
081-832-0066, Conduct Counseling Session														
081-832-0041, Initiate Follow-Up Action														
081-833-0076, Apply Restraining Devices														
081-833-0103, Provide Care for Battle Fatigue														
081-833-0088, Prepare Injection for Admin														
081-833-0089, Administer an Injection														
081-832-0069, Administer the MIMPI-2														
081-832-0070, Administer the WAIS-R														
081-832-1011, Respond to Agitated Patient														
081-832-1012, Assist in Manual Restraint														

EDITION OF DEC 82 TO BE USED

DA FORM 5165-R, SEP 85

FIELD EXPEDIENT SQUAD BOOK		SHEET	OF											
For use of this form, see AR 350-37; the proponent agency is DCSOPS														
USER APPLICATION	SOLDIER'S NAME													
TASK NUMBER AND SHORT TITLE	STATUS													
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-832-1013, Assist in Mechanical Restraint														
081-832-1014, Therapeutic Recreation Activities														
081-832-1023, Develop Therapeutic Relationship														
081-832-1024, Care for Patient Receiving ECT														
081-832-1025, Place a Patient in Seclusion														
081-832-1026, Monitor Response Psychotrop Med														
081-832-1001, Ensure Funds/Valuables Secured														
081-832-1002, Ensure Personal Effects Secured														
081-832-1003, Perform Admission Procedures														
081-832-1004, Prep Class 1A/1B Aeromed Evac														
081-832-1005, Prep Class 1C Aeromed Evac														
081-832-1027, Perform Discharge Procedures														
081-832-1006, Monitor Use Dangerous Item														

EDITION OF DEC 82 TO BE USED

DA FORM 5165-R, SEP 85



## GLOSSARY

<b>ABD</b>	abdominal
<b>ACCP</b>	The Army Correspondence Course Program
<b>ADAPCP</b>	Alcohol and Drug Abuse Prevention Control Program
<b>ADL</b>	activities of daily living

### **Army Training and Evaluation Program (ARTEP)**

The Army's collective training program that establishes unit training objectives critical to unit survival and performance in combat. They combine the training and the evaluation process into one integrated function. The ARTEP is a training program and not a test. The sole purpose of external evaluation under this program is to diagnose unit requirements for future training.

### **Battle focus**

A process to guide the planning, execution, and assessment of the organization's training program to ensure they train as they are going to fight.

**cc**                cubic centimeter

**CMS**            Centralized Materiel Service/Section

### **Collective training**

Training, either in institutions or units, that prepares cohesive teams and units to accomplish their missions on the battlefield and in operations other than war.

### **Common task**

A critical task that is performed by every soldier in a specific skill level regardless of MOS.

**CONUS**        Continental U.S.

### **Critical task**

A collective or individual task determined to be essential to wartime mission, duty accomplishment, or survivability. Critical individual tasks are trained in the training base and/or unit, and they are reinforced in the unit.

### **Cross training**

The systematic training of soldiers on tasks related to another duty position.

### **Drill**

A disciplined, repetitious exercise to teach and perfect a skill or procedure. Some examples are fire, man overboard, abandon ship, lifeboat, and damage control drills on Army watercraft.

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**ECT**            electroconvulsive therapy

**IAW**            in accordance with

**ID**              identification

**IM**              intramuscular

### **Individual training**

Training which prepares the soldier to perform specified duties or tasks related to assigned duty position or subsequent duty positions and skill level.

### **Integration training**

The completion of initial entry training in skill level 1 tasks for an individual newly arrived in a unit, but limited specifically to tasks associated with the mission, organization, and equipment of the unit to which the individual is assigned. It may be conducted by the unit using training materials supplied by the school, by troop schools, or by inservice or contract mobile training teams. In all cases, this training is supported by the school proponent.

**MAO**            monoamine anoxidase

### **Merger training**

Training that prepares noncommissioned officers to supervise one or more different military occupational specialties at lower skill levels when they advance to a higher skill level in their career management field.

**mg**              milligram

### **Mission essential task list (METL)**

A compilation of collective mission essential tasks which must be successfully performed if an organization is to accomplish its wartime mission(s).

**ml**              milliliter

**MOPP**          mission oriented protective posture

**MOS**            military occupational specialty

**MOSC**          military occupational specialty code

**MTF**            medical treatment facility

**NCO**            noncommissioned officer

**NPO**            nothing by mouth

<b>PIES</b>	proximity, immediacy, expectancy, simplicity
<b>prn</b>	as necessary
<b>PTF</b>	patient trust fund
<b>RON</b>	remain overnight

**Self-Development**

Self-development is a planned, progressive, and sequential program followed by leaders to enhance and sustain their military competencies. Self-development consists of individual study, research, practice, professional reading, and self-assessment.

<b>SL</b>	skill level
<b>SM</b>	soldier's manual
<b>SMCT</b>	Soldier's Manual of Common Tasks
<b>SOP</b>	standing operating procedure
<b>SQ</b>	subcutaneous
<b>SSN</b>	social security number

**Sustainment training**

The provision of training to maintain the minimum acceptable level of proficiency required to accomplish a critical task.

<b>TG</b>	trainer's guide
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**Train-up**

The process of increasing the skills and knowledge of an individual to a higher skill level in the appropriate MOS. It may involve certification.

**Unit training**

Training (individual, collective, and joint or combined) conducted in a unit.

## REFERENCES

### Required Publications

Required publications are sources that users must read in order to understand or to comply with this publication.

#### Other Product Types

MMPI-2 Manual	Minnesota Multiphasic Personality Inventory-2 Manual for Administration and Scoring
WAIS-R Manual	Wechsler Adult Intelligence Scale-Revised (WAIS-R) Manual

### Related Publications

Related publications are sources of additional information. They are not required in order to understand this publication.

#### Army Regulations

AR 20-1	Inspector General Activities and Procedures
AR 25-55	The Department of the Army Freedom of Information Act Program
AR 27-1	Legal Services, Judge Advocate Legal Services
AR 27-3	The Army Legal Assistance Program
AR 340-21	The Army Privacy Program
AR 40-2	Army Medical Treatment Facilities: General Administration
AR 40-4	Army Medical Department Facilities/Activities
AR 40-407	Nursing Records and Reports
AR 40-535	Worldwide Aeromedical Evacuation
AR 40-66	Medical Record Administration
AR 600-85	Alcohol And Drug Abuse Prevention And Control Program
AR 608-1	Army Community Service Program
AR 608-18	The Army Family Advocacy Program
AR 621-5	Army Continuing Education System (ACES)
AR 635-200	Enlisted Personnel
AR 930-4	Army Emergency Relief
AR 930-5	American National Red Cross Service Program and Army Utilization

#### Army Training and Evaluation Programs

ARTEP 8-057-30-MTP	Mission Training Plan for the Medical Company, Main Support Battalion, Heavy Division
ARTEP 8-437-30-MTP	Mission Training Plan for the Medical Company, Support Battalion, Heavy Separate Brigade/Separate Infantry Brigade, and Medical Troop, Support Squadron, Armored Cavalry Regiment

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ARTEP 8-456-MTP	Mission Training Plan for the Headquarters, Area Support Medical Battalion
ARTEP 8-467-30-MTP	Mission Training Plan for the Medical Company or Detachment, Combat Stress Control
ARTEP 8-705-MTP	Mission Training Plan for the Combat Support Hospital
ARTEP 8-715-MTP	Mission Training Plan for the Field Hospital
ARTEP 8-725-MTP	Mission Training Plan for the General Hospital (500 Bed)

### **Department of Army Pamphlets**

DA Pam 351-20	Army Correspondence Course Program Catalog
DA Pam 40-5	Army Medical Department Standards of Nursing Practice

### **Field Manuals**

FM 21-11	First Aid For Soldiers
FM 25-100	Training the Force
FM 25-101	Battle Focused Training
FM 8-230	Medical Specialist

### **Soldier's Training Publications**

STP 21-1-SMCT	Soldier's Manual of Common Tasks (Skill Level 1)
STP 21-24-SMCT	Soldier's Manual of Common Tasks (Skill Levels 2-4)

### **Other Product Types**

DOD Reg 6010.8-R	Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
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### **Department of Army Forms**

DA Form 2028	Recommended Changes to Publications and Blank Forms
DA Form 3696	Patient's Deposit Record
DA Form 3888	Medical Record - Nursing History and Assessment
DA Form 3949	Controlled Substances Record
DA Form 4015	Nursing Care Assignment
DA Form 4029	Patient's Clearance Record
DA Form 4160	Patient's Personal Effects and Clothing Record
DA Form 4677	Therapeutic Documentation Care Plan [Non-medications]
DA Form 4678	Therapeutic Documentation Care Plan (Medication)
DA Form 4700	Medical Record - Supplemental Medical Data

### **Department of Defense Forms**

DD Form 1380	US Field Medical Card
DD Form 599	Patient's Effects Storage Tag
DD Form 600	Patient's Baggage Tag
DD Form 602	Patient Evacuation Tag

**Standard Forms**

SF 509

Medical Record - Progress Notes

SF 510

Medical Record - Nursing Notes

SF 511

Medical Record - Vital Signs Record

SF 600

Health Record - Chronological Record of Medical Care

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29 SEPTEMBER 1997**

By Order of the Secretary of the Army:

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