

CHAPTER 2

ESTABLISHMENT OF THE DIVISION MEDICAL
OPERATIONS CENTER

Section I. COMMAND POST SETUP

**2-1. Command Post, Division Support
Command**

The DISCOM command post (CP) normally collocates with the division rear CP.

a. Command posts may be organized in many different ways to accomplish their missions. Figure 2-1 provides a sample layout of the DISCOM CP in a heavy division and Figure 2-2 provides a sample layout of the DISCOM Level II CP for light divisions. The three primary cells consist of the S2/S3 and plans intelligence branch, the division materiel management office, and the DMOC. Additionally, a separate commander's briefing area provides a workplace for the command section in the CP area. For definitive information on the DISCOM CP, see FMs 63-2 and 63-2-1.

b. The DMOC area of the CP is setup according to DISCOM TSOP. This setup is normally one that establishes only the necessary operations and communications equipment which supports the C2 operations requirement. An alternate area should be selected for placement of equipment not in use. This setup facilitates a timely and organized displacement without disruption of C2 operations capabilities. When the CP does move, it displaces by echelons. Once an interim operations capability is established at the new location, the remainder of the CP elements move. The jump DMOC as part of the jump DISCOM performs quartering party activities. (They select a site within the designated area, then select an alternate location. The selection of the alternate location is based on the enemy situation, terrain, and command guidance. Combat health support operations should not be disrupted as a result of relocating the DISCOM CP.)

2-2. Communications

Effective management and control of division CHS operations are dependent on the DMOC's ability to communicate with DISCOM and corps elements. Communications assets available to the DMOC include radios (AM and FM), and MSE. Communications support for the DISCOM HHC (DMOC) is provided by elements of the division signal battalion. For information on radio nets within the DISCOM, see FMs 63-2 and 63-2-1.

a. The DMOC maintains continual communications with division medical elements through its FM medical net or its AM medical operations net. Single-channel ground and airborne radio system (SINCGARS) components (see FM 24-24) provide the DMOC with an AN/VRC 89 (FM) which has a receiver/transmitter capable of using two FM nets for reception and transmission. This permits the DMOC to operate the medical net (FM). The medical operations net (AM-IHFR) uses an AN/GRC 213 radio. Division medical operations networks (technical and command) are depicted in Figure 2-3.

b. Mobile subscriber equipment is a part of the area common-user system (ACUS) and goes from the corps rear boundary forward to the division maneuver battalion's rear area. This system will allow the DMOC to communicate throughout the battlefield in either a mobile or static situation. The mobile subscriber system is managed by the organic MSE signal battalion which consists of an HHC, one or two area signal companies, and a signal support company. The signal support company normally provides subscriber services to the DISCOM CP/division rear. Additional information pertaining to MSE maybe found in FM 11-30 and FM 63-2.

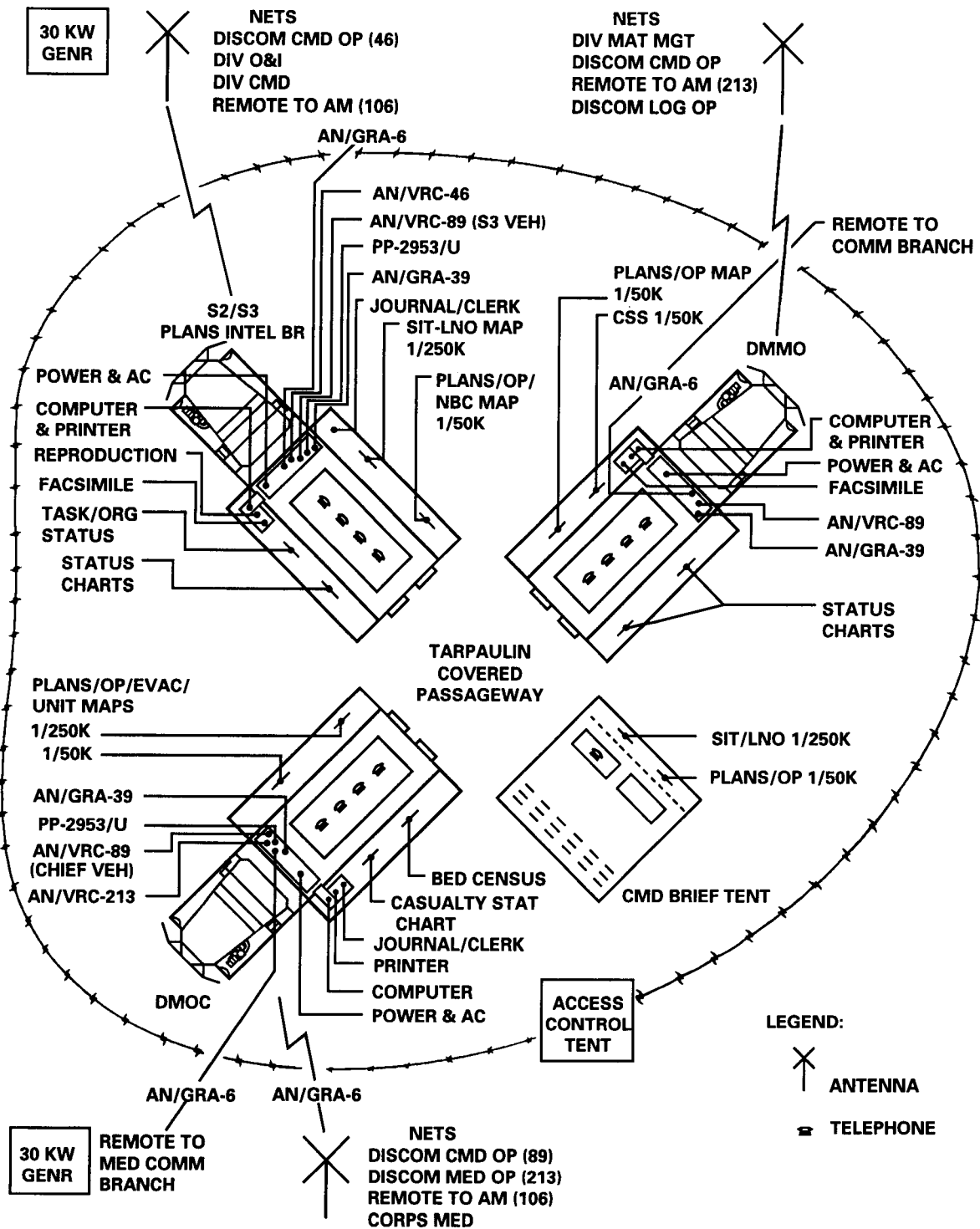
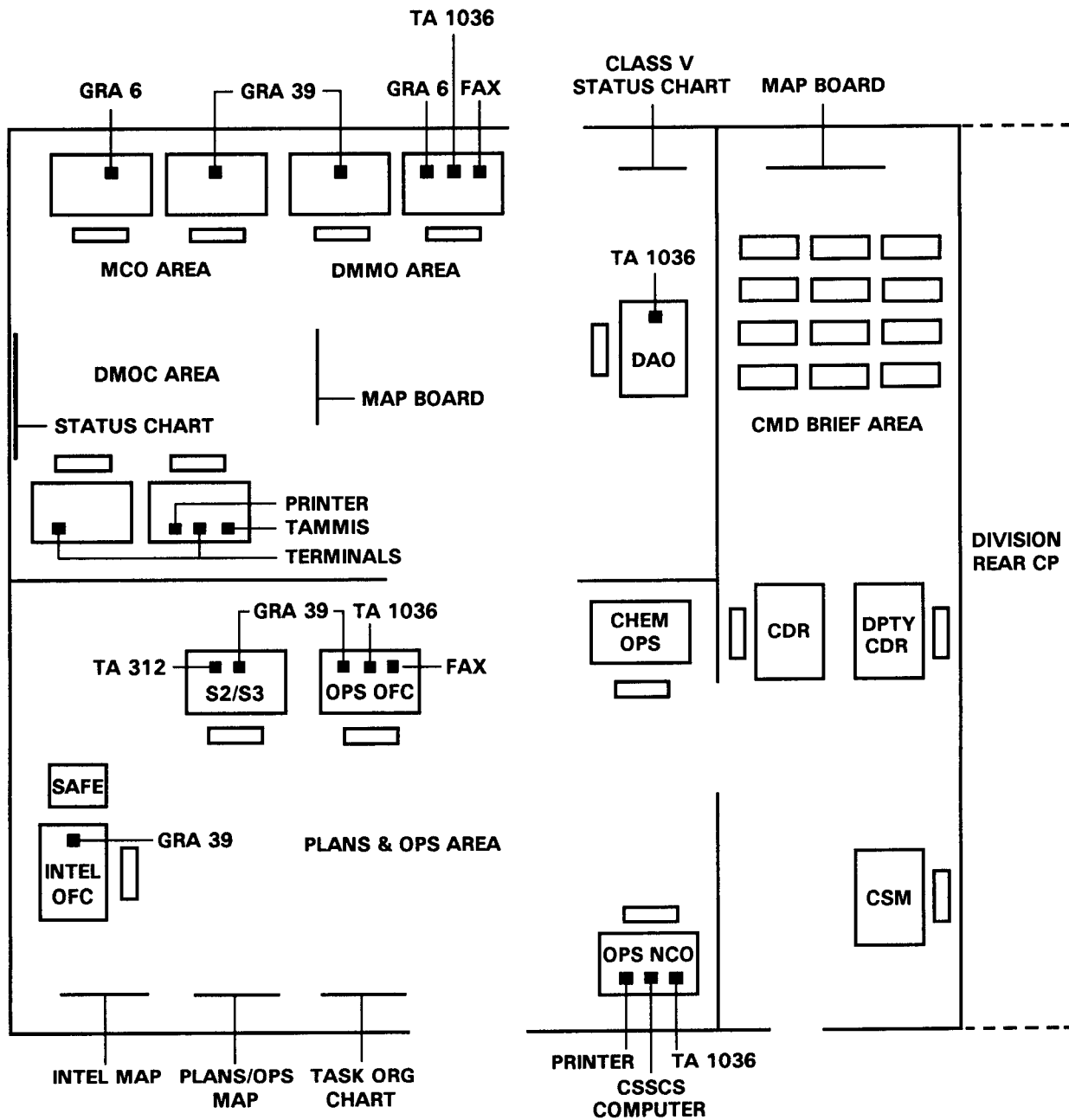


Figure 2-1. DISCOM command post, heavy.



DISCOM CP COMPRISED OF EIGHT SICP TENTS

Figure 2-2. DISCOM command post, light.

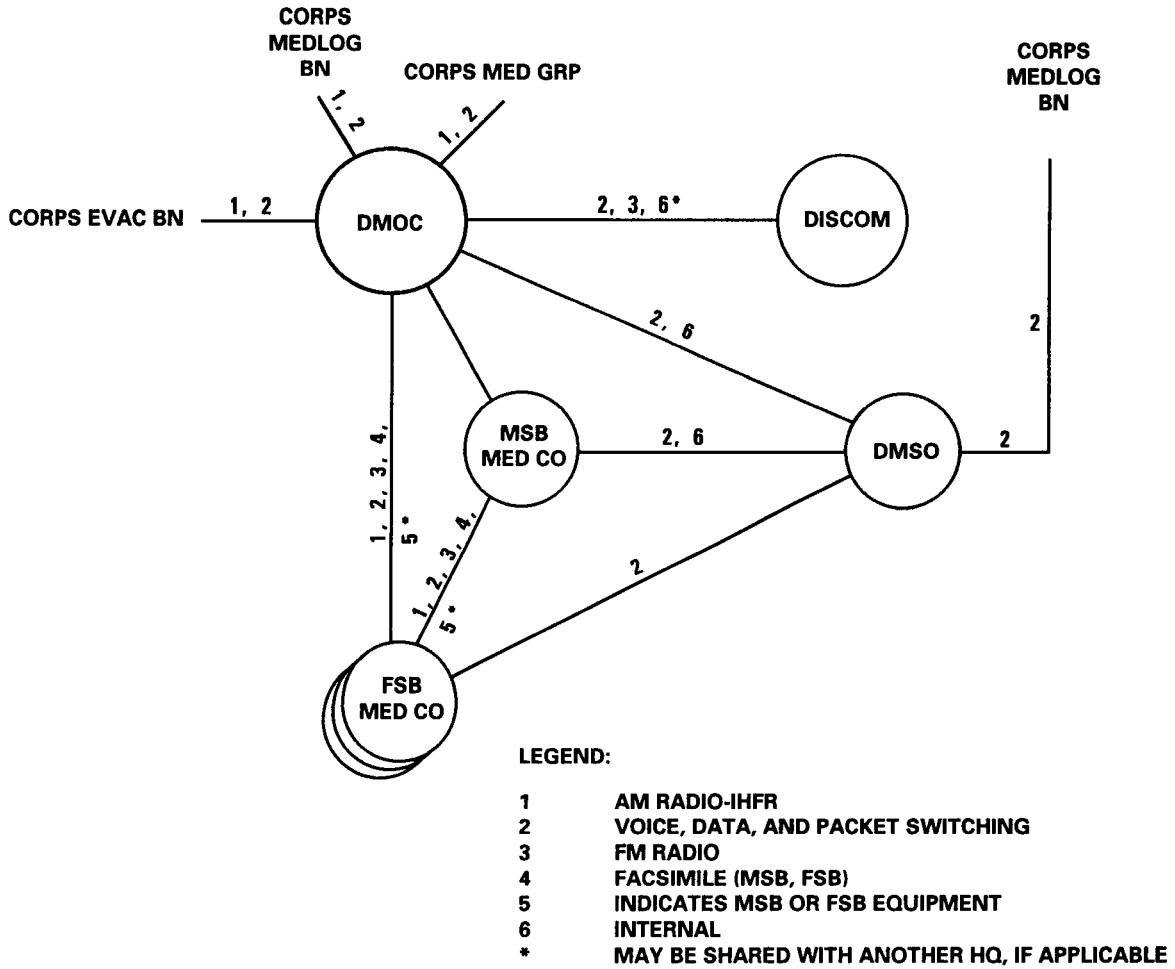


Figure 2-3. Division medical operations networks (technical and command).

(1) *Subscriber terminal fixed*). The MSE telephones, mobile subscriber radiotelephone terminals (MSRTs), facsimiles (FAXs), data terminals, and computer systems, as part of the ACUS, are user-owned and operated. The DMOC is responsible for running wire to the designated junction boxes. These boxes tie the DMOC MSE telephones into the extension switches which access the system. The subscriber terminals used by the units are digital nonsecure voice telephones. These provide full duplex digital, four-wire voice, as well as data ports, for interfacing the AN/UXC-7 FAX, the TACCS computer, and the unit-level computer (ULC). See FM 11-43 for information on how to connect terminals to communications systems,

(2) *Wire subscriber access*. Wire subscriber access points provide the entry points (interface) between fixed subscriber terminal equipment owned and operated by users and the MSE area system operated by signal units. See FM 63-2 for information pertaining to fixed subscriber terminal equipment assignments for the DMOC.

(3) *Mobile subscriber terminal access*. The MSE mobile subscriber terminal is the AN/VRC-97 MSRT terminal. This MSRT, which consists of a very high frequency radio and a digital *secure voice* terminal, is a vehicle-mounted assembly. It interfaces with the MSE system through a radio access unit. The primary use of the MSRT terminal is to provide mobile subscribers access to the MSE area network. See FM 11-43 for MSRT terminal interface into the area system. Radio access units are deployed to maximize area coverage and MSRT terminal concentrations. Mobile subscriber radiotelephone terminals can also operate in CPs to allow access to staff and functional personnel. Local standing operating procedures (SOP) will determine use of MSRTs in CP areas based on the possibility of interference with SINCGARS radios operating in the immediate area. As the Army continues to digitize the battlefield and modernize the force, the use of automation

continues to develop. Mobile subscriber equipment Packet Switching Network gives units the ability to connect to division and corps Local Area Networks (LANs). This allows units/CPs to connect computer systems to an ethernet cable (coaxial) and send and receive information in an extremely efficient manner. Packet switching does not utilize or take up existing telephone lines. Instead, telephone lines are freed up even more because information is being sent over a network on data packets.

c. Using the Army Tactical Command and Control System (ATCCS), common hardware/software facilitates the interface and exchange of information between the DMOC, corps, and division medical elements. See FM 63-2 for information concerning automatic data processing (ADP) continuity of the operations plan.

2-3. Patient Disposition and Reporting Procedures

Patient accountability within the medical treatment chain must be maintained at all times. Prompt reporting of patients and their health status to the next higher headquarters and servicing personnel service detachment (PSD) is necessary for the maintenance of a responsive personnel replacement system and the Army Casualty System. Patient accountability and status reporting is a requirement for—

- Providing the commander with an accurate account of casualties in the medical treatment chain.
- Verifying personnel replacement requirements.
- Quantifying and prioritizing division evacuation demands.
- Assisting the command surgeon in the preparation of the medical estimate.

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- Alerting PVNTMED officers and the intelligence community to probable environmental health hazards and probable enemy use of exotic munitions.
 - a. Employment of patient accountability and status reporting is accomplished as shown in Figure 2-4.

(1) The Daily Disposition Log (DDL) (see Appendix B for sample format) is maintained by Echelon I (unit-level) and Echelon II (division-level) MTFs. The information from this log is extracted, when required, and provided to the S 1 and G1 or supported unit requesting such information. The DDL is also the primary source for the information needed in the Patient Evacuation and Mortality Report (PE&MR).

(2) The PE&MR (see Appendix B for sample format) is prepared by Echelon III (corps-level) and Echelon II MTFs and disseminated as shown in Figure 2-4. The PE&MR primarily serves as a “medical spot report.” The

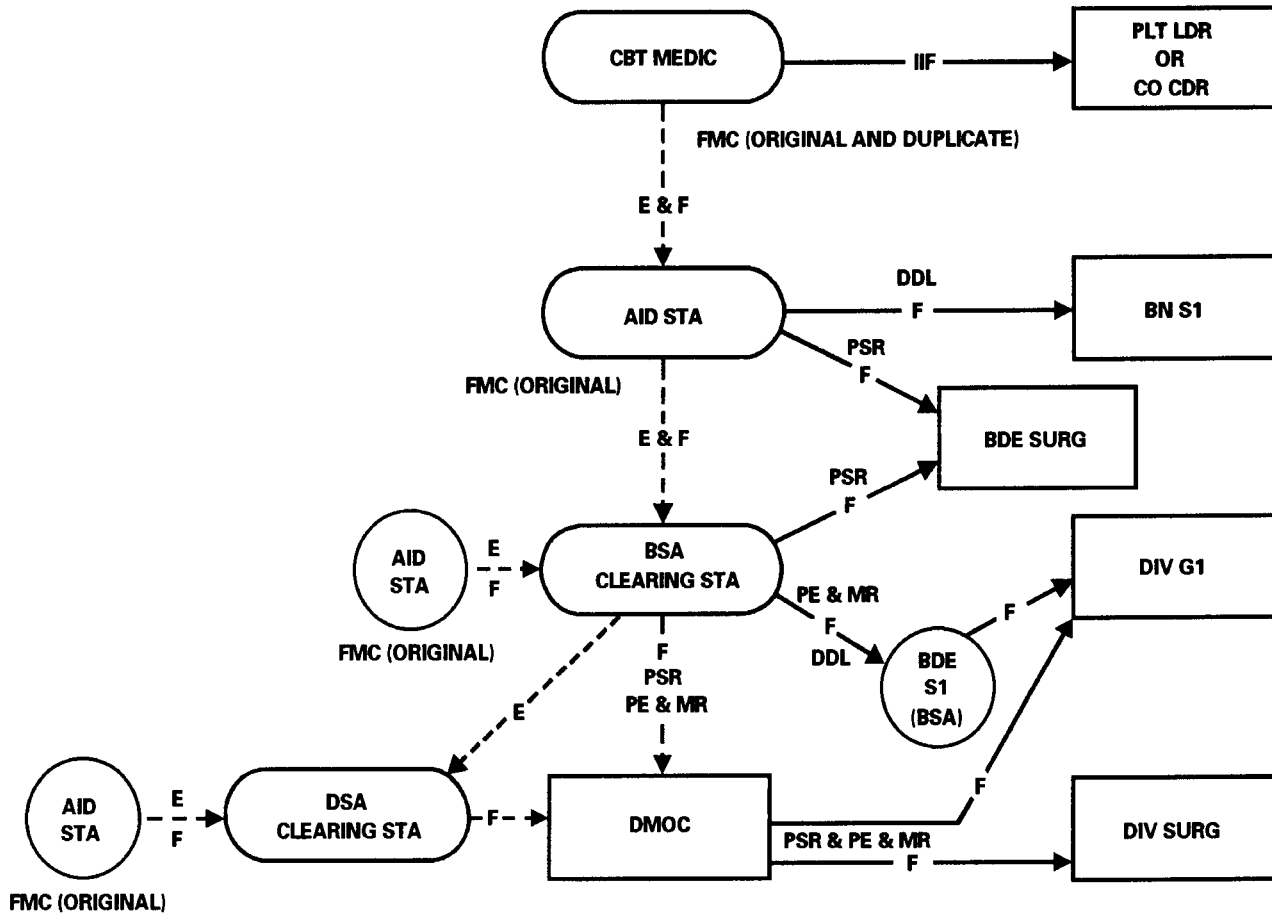
frequency of this report is established by the command surgeon.

(3) The Patient Summary Report (PSR) is a weekly report (see Appendix B for sample format). It is prepared by Echelon I through Echelon III MTFs and is submitted to respective surgeons as shown in Figure 2-4.

(4) The Admission and Disposition (AAD) Report is prepared and distributed by the patient administration element of the MTF (see AR 40-66).

b. The DMOC patient disposition and reporting procedures involve consolidating all patient and disposition reports that originate within the division. The DMOC will consolidate these reports and forward them to the division and corps headquarters according to the TSOP.

c. Reporting procedures for allied, host nation, and third country citizens are accomplished according to commanders guidance, standardization agreements, memorandum of understanding, or other appropriate regulatory guidance.



LEGEND:

- | | | | |
|-----|-------------------------|---------|-----------------------------------|
| DDL | DAILY DISPOSITION LOG | IIF | INFORMAL INFORMATION FLOW |
| E | PATIENT EVAC FLOW | PE & MR | PATIENT EVAC AND MORTALITY REPORT |
| F | FORMAL INFORMATION FLOW | PSR | PATIENT SUMMARY REPORT |
| FMC | FIELD MEDICAL CARD | | |

NOTE: - - - PATIENT FLOW AND INFORMATION
 ——— INFORMATION ONLY

Figure 2-4. Patient accountability and status reporting.

Section II. MONITORING AND MANAGING ACTIVITIES FOR ECHELON II COMBAT HEALTH SUPPORT ELEMENTS IN THE DIVISION

2-4. Medical Regulating from the Division

a. Medical regulating in and from the division is the responsibility of the patient disposition and reports branch of the DMOC. Medical regulating in the division is an informal system. It is procedurally operated to prevent sole dependence on communications. The patient disposition and reports branch is concerned with—

- Tracking the movement of patients throughout the division and into the corps.
- Monitoring the use of ambulance elements.
- Coordinating with the corps medical evacuation battalion.
- Maintaining communications with corps air and ground ambulance elements in support of the division.

b. Various techniques for regulating patients may be employed, depending on mission and operational constraints. The technique provided below is one of the many ways to accomplish medical regulating. Provided in the technique are medical regulating requirements for the division and corps areas.

(1) *Division area.* In this technique, corps hospital destinations are predetermined when corps medical evacuation elements deploy forward. The DMOC and the medical brigade/group MRO will coordinate patient evacuation to corps hospitals. The number and types of patients a supporting corps hospital can accept during a particular period

of time is established. Blocks of beds will be provided to corps ambulance elements by the corps MRO. This is accomplished through the DMOC and supporting medical companies prior to calling for a medical evacuation mission. Upon departure of ambulances from pickup sites, the originating MTF contacts the DMOC patient disposition and reports branch. Patient evacuation information is provided to the patient disposition and reports branch. This information includes—

- Patient numbers by category and precedence.
- Departure times.
- Modes of transportation.
- Destination facilities.
- Any other information established by TSOP.

(2) *Corps area.*

(a) The DMOC notifies the medical brigade/group MRO and provides the information collected in (1) above via the medical operations (AM) net. This net should be monitored by corps hospitals. Since corps ground ambulances currently are without on-board communications and corps air ambulances are without AM-high frequency (HF) capabilities, all patient information must be passed to gaining facilities via the patient administration net from division to corps. The corps MRO must constantly search for methods which will reduce ground ambulance turnaround time and expedite the evacuation of seriously injured or seriously ill patients. Factors which will influence or alter the medical regulating of patients include—

- Time and distance.
- Weather.
- Available ambulance assets.
- Flight time for air ambulances (amount of time before required maintenance).
- Threat.
- Number of patients requiring medical evacuation.

routes to designated hospitals are blocked by the enemy.

- Coordinating the use of nonmedical vehicles for evacuating patients.

(b) The corps MRO, DMOC, and evacuation battalion must be prepared to initiate procedures which will compensate or maintain acceptable levels of medical evacuation support as a result of the factors identified in (a) above. Some of their options include—

- Using air ambulances to support units on the move.
- Limiting the use of air ambulances to only those patients assigned an URGENT, URGENT SURG, or PRIORITY category.
- Directing ground ambulances to the nearest combat support hospitals (CSHs).
- Using AXPs.
- Redirecting ground ambulances when

c. Patient regulating from the FSMCs to the mobile army surgical hospital (MASH) is coordinated by the DMOC. This coordination involves the MASH patient administration and disposition (PAD) section and the patient disposition and reports branch of the DMOC. The DMOC updates the brigade/group MRO when patients are evacuated from the division to the MASH.

d. Medical evacuation can be accomplished under conditions of communications silence by ensuring SOPS include—

- Establishing work load planning data.
- Completing casualty estimates.
- Prioritizing and task-organizing ambulance support.
- Assigning blocks of hospital bed designations.
- Following a predetermined route and schedule to collect patients.

2-5. Division Medical Supply Office

a. *Responsibilities.* The DMSO is assigned to the MSMC. It is responsible for providing medical supply and unit-level medical maintenance support to the medical treatment

elements within the division. The HSMO of the DMSO manages Class VIII supplies and equipment; he also executes the CHL plan. The HSMO of the DMOC monitors and provides technical staff supervision for DMSO operations.

b. *Functions.*

(1) The functions of the DMSO include—

- Developing and maintaining prescribed loads of contingency medical supplies for division medical elements.
- Managing the medical quality control program.
- Supervising unit (organizational) medical maintenance support,
- Monitoring the division medical assemblage management program.
- Coordinating the CHL requirements for preconfigured Class VIII packages with the DMOC MMB and the corps MEDLOG battalion (forward).

(2) The DMSO will use the TAMMIS-medical supply (MEDSUP). This system will interface with the MEDLOG battalion (forward) using the Army Tactical Command and Control System—Common Hardware/Software (ATCCS-CHS) computers, TAMMIS, and commercial off-the-shelf software systems.

(3) This office is also involved in the logistical aspects of the division blood

management program and optical fabrication and repair.

c. *Medical Resupply.* The DMSO normally performs its mission by operating under the supply point distribution system. While each medical unit maintains its own basic load (2 days of supply) of medical supplies, the DMSO carries the division operating stocks. The DMSO normally stocks 5-to 15-day levels of selected medical supply items. The number of days of supply and any additional items maintained by the DMSO are determined by the division's mission, its location, and guidance from the division surgeon and the DMOC medical materiel manager.

(1) During the initial employment phase, each FSMC receives a preconfigured medical resupply push-package every 48 hours from the DMSO until appropriate elements of the corps MEDLOG battalion (forward) are established.

(2) During deployment, lodgment, and early buildup phases, medical units operate from planned, prescribed loads and from existing pre-positioned war reserve stockpiles identified in applicable contingency plans.

(3) Initial resupply efforts may consist of preconfigured medical supply packages tailored to meet specific mission requirements. Resupply by preconfigured packages will normally be shipped directly (push-packages) to the division until replenishment line item requisitioning is established with the supporting MEDLOG battalion (forward). While resupply by preconfigured packages is intended to provide support during the initial phase, continuation on an exception basis may be dictated by operational needs. Planning for such a contingency must be directly coordinated with the DMSO who will coordinate further Class VIII requirements with the supporting MEDLOG battalion (forward). Shipment of medical materiel from the DSA is coordinated with the division support operations branch, or is achieved through

use of the backhaul method using returning medical evacuation resources when possible.

d. Medical Resupply Operations.

NOTE

In contrast to the formal procedures normally associated with support between the combat zone MEDLOG battalion (forward) and the DMSO, requests submitted to the DMSO from the division MTFs may be informal. Request may come by message with returning ground or air ambulances, by land lines, or through FM command nets within the division.

(1) *From requesting units.*

(a) *Routine.* The DMSO receives requests from supported units using the Customer Reorder List (resupply requisition format submitted through command channels). If requested items are available for issue, a Materiel Release Order is printed and stock issued to the unit. For items not available for issue, the requests are passed to the next higher level of supply.

(b) *Emergency.* All emergency requests are immediately processed by the DMSO and issued to requesting unit. The medical materiel branch of the DMOC has the responsibility of monitoring all emergency requirements not immediately filled by the DMSO. The medical materiel branch (DMOC) coordinates with the DISCOM's support operations branch for the transportation of emergency medical supplies, if required.

(2) *From source of supply.*

(a) *Routine.* The DMSO requests all supplies according to TAMMIS users manual (MEDLOG). All supplies are forwarded using supply point distribution.

(b) *Emergency.* The DMSO immediately forwards all emergency requests not filled to the next source of supply. The medical materiel branch (DMOC) coordinates, as required, with the DISCOM's support operations branch to meet shortfalls in the supply point distribution system by updating priorities with the MEDLOG battalion (forward).

(3) *Medical materiel branch.* The medical materiel branch (DMOC) is informed by the DMSO of all pertinent management indicators.

(a) Number of stocked lines.

(b) Demand satisfaction/accommodation.

(c) Zero balances.

(d) Critical item shortages.

(e) Nonoperational critical equipment.

e. Records and Reports. Records and reports are maintained according to the TAMMIS users manual. (In the event of a TAMMIS failure, a backup manual system will be implemented.)

f. Division Medical Maintenance. Medical equipment repairers are assigned to the DMSO to support division units and those units attached to the division. The maintenance of medical equipment is an important responsibility of the DMSO. The DMSO medical maintenance personnel must develop a program to ensure the division's medical equipment is operational and ready to go to war. Implementation of the following programs of functions ensures the readiness of medical equipment:

(1) *Periodic services.* Services consist of preventive maintenance, safety checks, and calibration. These services must be scheduled on a

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periodic basis and should be placed on unit training schedules. The frequency of each scheduled service should be in compliance with technical manuals and other publications. Considerations for these services include—

- Availability of equipment and manpower resources.
- Availability of test, measurement, and diagnostic equipment (TMDE).
- Other taskings.

(2) *Repairs.* Repair work orders must be completed in a timely manner to maintain a high readiness posture and prevent a backlog from occurring and to maintain a high readiness posture. A repairman will either repair the equipment, calibrate it, order parts required to effect repair, or evacuate the equipment for repair. Equipment is evacuated to the MEDLOG battalion (forward) when necessary repairs exceed the unit's TMDE or repair capability. The medical materiel section of the DMOC coordinates with the MEDLOG battalion (forward) for use of maintenance support (contact) teams and the evacuation of equipment.

(3) *Records.* Records for medical equipment are kept according to AR 40-61, Technical Bulletin (TB) 38-750-2, and the Supply Bulletin (SB) 8-75 Series. These should be reviewed periodically by the DMSO. Examples of required records for medical equipment (the majority of which TAMMIS-medical maintenance [MEDMNT] has automated) areas follows:

(a) DA Form 2404, Equipment Inspection and Maintenance Worksheet.

(b) DA Form 2405, Maintenance Request Register.

(c) DA Form 2407, Maintenance Request and DA Form 2407-1, Maintenance Request (Continuation).

(d) DA Form 2409, Equipment Maintenance Log (Consolidated).

(e) DA Form 3318, Records of Demands—Title Insert.

(f) DA Form 3321, Request for Acknowledgment of Loaned Durable Medical Equipment.

(g) DA Form 5621-R, General Leakage Current Requirements (LRA).

(h) DA Form 5624-R, DC Defibrillator Inspection Record (LRA).

(i) DA Label 175, Defibrillator Energy Output Certificate.

(j) DD Form 314, Preventive Maintenance Schedule and Record.

(k) DD Form 2163, Medical Equipment Verification and Certification.

(l) DD Form 2164, X-ray Verification and Certification Worksheet.

(4) *Repair parts.* Mandatory parts lists (MPLs) and prescribed load lists (PLLs) need to be monitored routinely. An MPL to support medical equipment is published annually in SB 8-75 Series. Most medical equipment repair parts can be requisitioned through the Class VIII system; however, some repair parts needed to repair medical equipment fall in the category of Class IX repair parts (that is, common fasteners, electrical components, and others). Requisitions for Class IX repair parts are sent through the organization's supporting motor pool and require stringent monitoring and follow-up efforts. Special considerations for medical repair parts are explained in AR 40-61.

g. Division Blood Management.

(1) Blood requirements for the division are determined by the division surgeon. Only packed liquid red blood cells are expected to be available to the division. Blood products are provided to Army MTFs in the division by the DMSO. The DMSO coordinates through the MSMC to identify backhaul ambulances to transport blood to the requesting unit. The DMSO obtains packed liquid red blood cells from the MEDLOG battalion (forward). Shipment of blood from the corps to the division is either coordinated by the MEDLOG battalion (forward) with the corps movement control center (MCC) or accomplished by backhaul on medical vehicles' (air and ground). Emergency resupply can be accomplished by air ambulances from the medical battalion, evacuation. Most of the demands for emergency resupply come from the FSMCs.

(2) Blood support is a combination of four systems (medical, technical, operational, and logistical). Blood support must be considered separate from laboratory support. The distribution of all resuscitative fluids (including albumin) is managed by the MEDLOG units. In the long term, theater blood management is based on resupply from the continental United States (CONUS) donor bases (Armed Services Whole Blood Processing Laboratories [ASWBPLs]). At the division level, storage and transportation refrigerators allow the DMSO to provide blood as far forward as the FSMC. The DMSO obtains liquid blood from the MEDLOG battalion (forward). See FMs 8-10, 8-10-9, and 8-55 for definitive information on blood management.

(3) The DMSO informs the medical materiel branch (DMOC) of the current availability of blood in the division. The DMOC prioritizes the movement of blood products as required. Air assets should be considered along with ground assets for the transportation of blood.

h. Medical Logistics Battalion Support.

(1) The MEDLOG battalion (forward) is a modular organization with the primary mission of providing C2. It provides staff planning, supervision of operations, and administration of assigned or attached units (see FM 8-10-9). This unit provides Class VIII supplies, optical fabrication (single vision), medical equipment maintenance support, and blood storage, processing, and distribution. It provides unit and supply point distribution to divisional and nondivisional units. The MEDLOG battalion (forward) is a corps asset and is under the C2 of the medical brigade or medical group.

(2) All requests from the division are submitted to the MEDLOG battalion (forward) according to the TAMMIS users' manual.

2-6. Division Preventive Medicine Section

The division PVNTMED section is responsible for—

- Supervising the command PVNTMED program (see AR 40-5).
- Ensuring PVNTMED measures that protect division personnel against food-, water-, and vectorborne diseases, as well as environmental injuries (for example, heat and cold injuries), are implemented.

This section is assigned to the MSMC. Its missions in the division are monitored according to the division CHS plan and coordinated as appropriate by the DMOC. The PVNTMED section is staffed to provide advice and consultation in the areas of environmental sanitation, epidemiology, and entomology, as well as limited sanitary engineering services and pest management. Additional information pertaining to PVNTMED staff and specific functions is discussed in FM 8-10.

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a. Preventive medicine activities begin prior to deployment to minimize disease and nonbattle injuries (DNBIs).

(1) Actions taken include—

- Ensuring command awareness of potential medical threats and that appropriate PVNTMED measures are implemented.
- Monitoring immunization and chemoprophylaxis status of division personnel.
- Monitoring the status of individual and small unit PVNTMED measures.
- Monitoring PVNTMED measures against heat and cold injuries and food-, water-, and vectorborne diseases.

(2) Commanders and PVNTMED planners must be proactive and initiate action on presumptive information to reduce the medical threat early. They cannot wait until the incapacitation of troops occurs before taking action; for example—

- Mosquito populations near troop assembly areas must be suppressed without waiting for confirmation that they do indeed carry malaria or other disease-causing organisms.
- Sand flies in towns along routes of march must be suppressed without waiting for the incubation period of sandfly fever to lapse.

- Inadequate sanitation practices must be brought to the attention of responsible commanders before the first case of dysentery appears.

Lack of, or delay in, implementing preemptive actions can significantly impact on the deployment force's ability to accomplish its assigned mission.

b. Supported units can request PVNTMED support through the division medical channel. The DMOC is notified when a request for PVNTMED support is submitted through the medical companies. The DMOC or MSB coordinates PVNTMED missions for either requested or preemptive actions.

c. Preventive medicine operations are characterized by preemptive action, increased soldier and commander involvement, and priority to combat units. To accomplish this, the PVNTMED section may be deployed as a team to support specific units or operations (for example, deployed in DS of a brigade- or battalion-sized task force) as required. Such teams are task-organized by the division PVNTMED officer based on the particular medical threat. Preventive medicine section operations and activities may include—

- Assisting the surgeon in staff estimate preparation by identifying the medical threat.
- Assisting the division surgeon in determining disease prevalence in the AO.
- Conducting surveillance of divisional units to ensure implementation of PVNTMED measures at all levels and to identify actual or potential health threats and recommending corrective action as required.

- Assisting divisional units in the training of PVNTMED measures against heat and cold injury, as well as food-, water-, and vectorborne diseases.
- Monitoring the immunization and chemoprophylaxis program.
- Monitoring the health-related aspects of water production, distribution, and consumption.
- Monitoring DNBI incidence to optimize early recognition of disease trends and recommending initiation of preemptive disease suppression measures.
- Conducting epidemiological investigations of disease outbreaks and recommending PVNTMED measures to minimize effect.
- Monitoring division-level re-supply of disease prevention-related supplies and equipment, including water disinfectants, insect repellents, and pesticides.
- Conducting limited entomological investigations and control measures.
- Monitoring environmental and meteorological conditions, assessing their health-related impact on division operations, and recommending PVNTMED measures to minimize heat and cold injuries, as well as selected arthropodborne diseases.
- Assessing the effectiveness of field sanitation teams.

- Deploying PVNTMED teams in support of specific units or operations as required.
- Training unit field sanitation teams (see FM 21-10-1).

2-7. Division Mental Health Section

The DMHS is the medical element in the division with primary responsibility for assisting the command in controlling combat stress. Combat stress is controlled through sound leadership, assisted by CSC training, consultation, and restoration programs conducted by this section. The DMHS enhances unit effectiveness and minimizes losses due to battle fatigue (BF), misconduct stress behaviors, and neuropsychiatric (NP) disorders. Under the direction of the division psychiatrist, the DMHS provides mental health/CSC services throughout the division. This section, acting for the division surgeon, has staff responsibility for establishing policy and guidance for the prevention, diagnosis, treatment, and management of NP, BF, and misconduct stress behavior cases within the division AO. It has technical responsibility for the psychological aspect of surety programs. The staff of this section provides training to unit leaders and their staffs, chaplains, medical personnel, and troops. They monitor morale, cohesion, and mental fitness of supported units. Other responsibilities for the DMHS staff include—

- Monitoring indicators of dysfunctional stress in units.
- Evaluating NP, BF, and misconduct stress behavior cases.
- Providing consultation and triage as requested for medical/surgical patients exhibiting signs of combat stress or NP disorders.

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- Supervising selective short-term restoration for Hold category BF casualties (1 to 3 days).
- Coordinating support activities of attached corps-level CSC elements.

The DMHS normally collocates with the MSMC clearing station (treatment platoon). The staffing of the DMHS allows for this section to split into teams which deploy forward to provide CSC support to the brigades in the division. One DMHS NCO and one mental health officer (social worker or psychologist) will routinely support each maneuver brigade as its CSC team. For definitive information pertaining to the DMHS, see FMs 8-10-1 and 8-51.

2-8. Division Optometry Section

The optometry section provides—

- Optometry services, including routine vision evaluation and refractions.
- Evaluation and management of ocular injuries and diseases.
- Eyewear frame assembly using finished single-vision lenses.
- Eyewear repair services within the division AO.

a. The optometry section is assigned to the MSMC and is staffed to provide optometry support in remote locations and forward areas as required.

NOTE

Optometrists manage ocular diseases and injuries according to medical protocols (established by the division surgeon or

higher medical authority) and refer patients to other health care providers as appropriate.

b. All division optometry sections are staffed with two optometry officers, an eye sergeant, two eye specialists and an optical laboratory specialist. Figure 2-5 depicts the eyewear repair or fabrication flow. See FMs 8-10-1 and 8-10-24/Change 1 for additional information on the optometry section.

2-9. Division Dental Services

The primary mission of division dental elements is prevention and treatment of dental disease. A dental officer and a dental specialist are assigned to the MSB and each FSB.

a. The senior dental officer assigned to the MSB serves as the division dental surgeon. He exerts technical control over all division dental elements. He advises both the division and DISCOM surgeons on dental activities within the division. His responsibilities include—

- Advising the division and DISCOM surgeons on the dental health of the command.
- Coordinating through the DMOC for corps dental support, as required.
- Planning and supervising the preventive dentistry program for the division according to AR 40-35.

b. Division dental personnel are responsible for—

- Monitoring the dental health of the command.

- Providing emergency and sustaining dental care.
- Conducting the division preventive dentistry program.
- Assisting the medical treatment elements in mass casualty situations.
- Assisting mortuary affairs personnel in the identification of remains.

NOTE

Identification of casualty remains is a part of the overall mortuary affairs operation undertaken by Quartermaster Corps units. Mortuary affairs operations are not a doctrinal AMEDD function; however, dental personnel and units are uniquely qualified to support such operations when needed in the identification process.

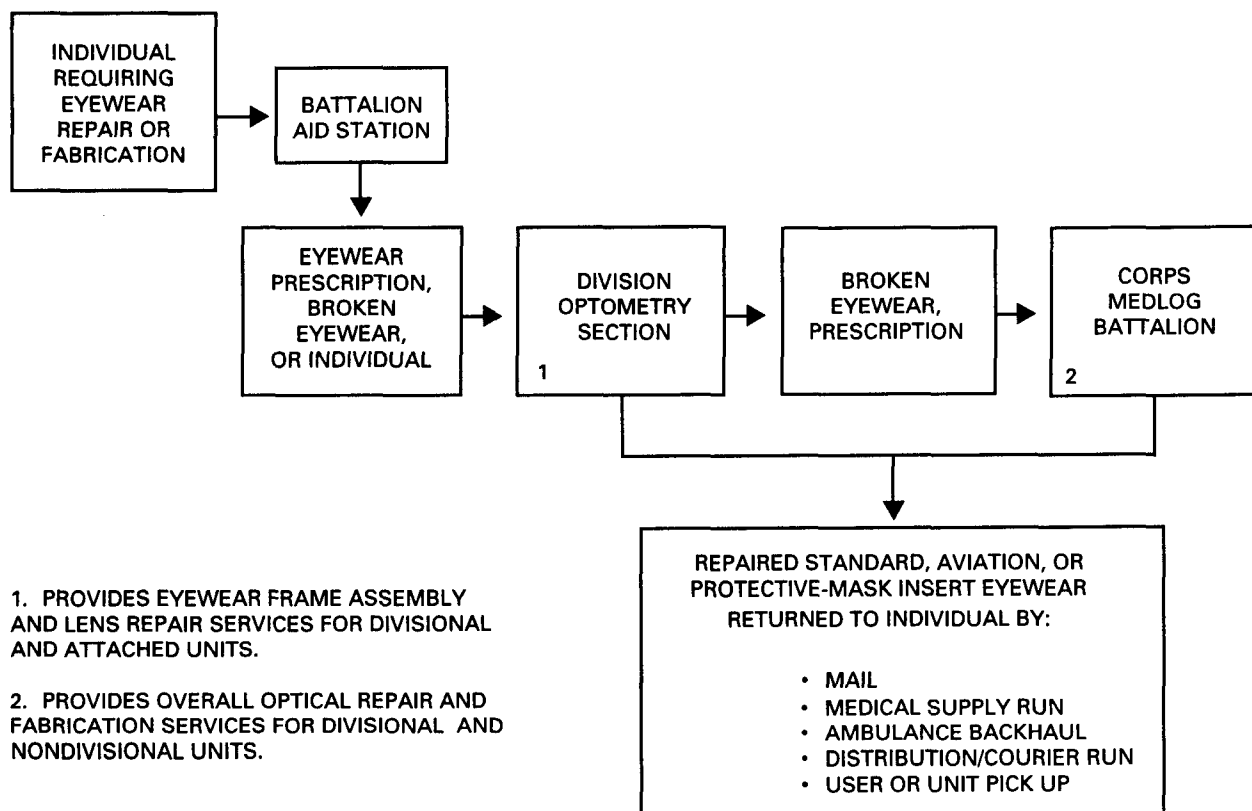


Figure 2-5. Eyewear repair or fabrication flow.