*U.S.GPO:1996-706-269/40003

HOME PHONE #

REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION

REQUESTING ACTIVITY - Complete Items 1 through 10 *(Except 8b)*; also complete Item 19.

ADDRESSEE - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, final referrer shall return to requester.

DATE X

1. PATIENT *(Last Name - First Name - Middle Name)*
X

2. ORGANIZATION AND PLACE OF TREATMENT
X

3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*
X

4. TO *(Include ZIP Code)*

5. IDENTIFYING INFORMATION
a. SERVICE NUMBER
b. GRADE/RATE
c. SOCIAL SECURITY ACCOUNT NO.
X
d. VA CLAIM NUMBER
e. DATE OF BIRTH *(If Federal employee)*

6. DATES OF TREATMENT *(Inclusive)*
X

7. DISEASE OR INJURY
X

8. a. RECORDS REQUESTED / b. RECORDS FORWARDED

MIL	VA		MIL	VA
☐	☐	CLINICAL	☐	☐
☐	☐	OUTPATIENT	☐	☐
☒		HEALTH RECORD	☐	
☐	☐	DENTAL RECORD	☐	☐
☐	☐	X-RAY	☐	☐
☐		MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	☐	
	☐	ABSTRACT OF RATING SHEET		☐
☐	☐	REPORT OF PHYSICAL EXAMINATION	☐	☐
☐		ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)*	☐	
☐	☐	OTHERS *(List under remarks)*	☐	☐

9. REMARKS
X

10. SIGNATURE
X

REPLY/REFERRAL

11. TO:

12. REMARKS
☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:

16. REMARKS
☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. SIGNATURE

18. DATE

19. RETURN TO: *(Include ZIP Code)*

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.