

**MEDICAL RECORD**

**CONSULTATION SHEET**

**REQUEST**

TO:	FROM: <i>(Requesting physician or activity)</i>	DATE OF REQUEST
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REASON FOR REQUEST *(Complaints and findings)*

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> TODAY
		<input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> 72 HOURS	<input type="checkbox"/> EMERGENCY

**CONSULTATION REPORT**

RECORD REVIEWED <input type="checkbox"/> YES <input type="checkbox"/> NO	PATIENT EXAMINED <input type="checkbox"/> YES <input type="checkbox"/> NO	TELEMEDICINE <input type="checkbox"/> YES <input type="checkbox"/> NO
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*(Continue on reverse side)*

SIGNATURE AND TITLE			DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT	
RELATION TO SPONSOR	SPONSOR'S NAME <i>(Last, first, middle)</i>	SPONSOR'S ID NUMBER <i>(SSN or Other)</i>	
PATIENT'S IDENTIFICATION <i>(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)</i>		REGISTER NO.	WARD NO.

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