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

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

2. ORGANIZATION AND PLACE OF TREATMENT

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

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

4. TO *(Include ZIP Code)*

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

6. DATES OF TREATMENT *(Inclusive)*

ALL PREVIOUS

7. DISEASE OR INJURY

MAMMOGRAMS & BREAST ULTRASOUNDS

8. a. RECORDS REQUESTED / b. RECORDS FORWARDED

MIL (a)	VA (a)		MIL (b)	VA (b)
☐	☐	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

Please forward all previous mammograms

and breast ultrasounds with reports

for comparison.

Thank you.

10. SIGNATURE

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)*

DEPARTMENT OF THE NAVY
NAVAL HEALTHCARE NEW ENGLAND
RADIOLOGY DEPARTMET
43 SMITH ROAD
NEWPORT, RI 02841-1002

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