

|                       |  |                             |
|-----------------------|--|-----------------------------|
| <b>MEDICAL RECORD</b> | <b>NARRATIVE SUMMARY (CLINICAL RESUME)</b> |                             |
| DATE OF ADMISSION     | DATE OF DISCHARGE                          | NUMBER OF DAYS HOSPITALIZED |

(Sign and date at end of narrative)

(Use additional sheets of this form (Standard Form 502) if more space is needed.)

|                          |   |                    |              |
|--------------------------|---|--------------------|--------------|
| SIGNATURE OF PHYSICIAN   | DATE  | IDENTIFICATION NO. | ORGANIZATION |
| PATIENT'S IDENTIFICATION | <i>(For typed or written entries give: Name-last, first, middle; grade; rank; rate; hospital or medical facility)</i> |                    | REGISTER NO. |
|                          |   |                    | WARD NO.     |

NARRATIVE SUMMARY (CLINICAL RESUME)  
Medical Record