

MEDICAL RECORD	CONSULTATION SHEET
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REQUEST

TO:	FROM: (Requesting physician or activity)	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

RECORDS REVIEWED YES NO PATIENT EXAMINED YES NO TELEMEDICINE YES NO

(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 (Last, first, middle)	SPONSOR'S ID NUMBER (SSN or Other)	
PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.

CONSULTATION SHEET
Medical Record