

MEDICAL RECORD**CONSULTATION SHEET****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 REPORTRECORD REVIEWED YES NOPATIENT EXAMINED YES NO

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)

USAPPC V1.00

CONSULTATION SHEET

Medical Record