TELEPHONE MEDICAL ADVICE/CONSULTATION RECORD For use of form, see AR 40-66; the proponent agency is the OTSG.		NAME *(Last, First, MI)*	TELEPHONE NO.
ORGANIZATION OF PATIENT/SPONSOR	FMP	SSN OF PATIENT/SPONSOR	LOCATION OF PATIENTS MEDICAL RECORD ☐ CENTRAL FILES AREA ☐ OTHER *(Specify)*
HOSPITAL AND CLINIC IDENTIFICATION	SERVICE AFFILIATION ☐ ARMY ☐ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ OTHER *(Specify)*		
	BENEFICIARY CATEGORY ☐ AD ☐ DEPN AD ☐ RET ☐ DEPN RET ☐ DEPN RET/DECD ☐ OTHER *(Specify)*		
DATE AND TIME OF CALL	PATIENT STATUS ☐ INPATIENT ☐ OUTPATIENT ☐ EMERGENCY ☐ NON-EMERGENCY		
SUMMARY *(Include complaint, diagnosis, instructions to patient)*			
☐ CHECK IF CONTINUED ON REVERSE	SIGNATURE OF PHYSICIAN/CARE PROVIDER		

DA FORM 5008, OCT 81

(Continuation of summary and/or follow-up note)

SIGNATURE OF PHYSICIAN/CARE PROVIDER

INSTRUCTIONS FOR COMPLETION AND PROCESSING OF FORM

1. The upper portion of the form, pertaining to patient information, will generally be completed by the individual responsible for screening incoming calls.

2. The entire set will be provided the physician/care provider for documenting the conversation.

3. The duplicate of the form will be retained for processing in accordance with local policy for medical summary reporting purposes.

4. For outpatient calls, the original form will be forwarded to the custodian of the patient's outpatient treatment record/HREC for attaching to a SF 600 therein.

5. For inpatient calls, the original form is forwarded to the custodian of the patient's inpatient treatment record.