

REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION	REQUESTING ACTIVITY - Complete Items 1 through 10 (<i>Except 8b</i>); 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 (<i>Last Name - First Name - Middle Name</i>)	3. STATUS <input type="checkbox"/> MILITARY <input type="checkbox"/> VA BENEFICIARY <input type="checkbox"/> DEPENDENT <input type="checkbox"/> FEDERAL EMPLOYEE <input type="checkbox"/> OTHER (<i>Specify</i>)	
2. ORGANIZATION AND PLACE OF TREATMENT	3a. NAME OF SPONSOR (<i>If dependent</i>)	
4. TO (<i>Include ZIP Code</i>) <div style="border: 1px solid black; width: 100%; height: 100%; margin: 5px 0;"></div>	5. IDENTIFYING INFORMATION	
	a. SERVICE NUMBER	
	b. GRADE/RATE	
	c. SOCIAL SECURITY ACCOUNT NO.	
	d. VA CLAIM NUMBER	
		e. DATE OF BIRTH (<i>If Federal employee</i>)
6. DATES OF TREATMENT (<i>Inclusive</i>)	7. DISEASE OR INJURY	
8. a. RECORDS REQUESTED	b. RECORDS FORWARDED	9. REMARKS
<input type="checkbox"/> MIL <input type="checkbox"/> VA CLINICAL	<input type="checkbox"/> MIL <input type="checkbox"/> VA	
<input type="checkbox"/> <input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> HEALTH RECORD	<input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> DENTAL RECORD	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> X-RAY	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	<input type="checkbox"/>	
<input type="checkbox"/> ABSTRACT OF RATING SHEET	<input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> REPORT OF PHYSICAL EXAMINATION	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> ALL AVAILABLE RECORDS (<i>Except X-rays unless specifically requested</i>)	<input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> OTHERS (<i>List under remarks</i>)	<input type="checkbox"/> <input type="checkbox"/>	10. SIGNATURE
REPLY/REFERRAL		
11. TO:		12. REMARKS <input type="checkbox"/> RECORDS CHECKED IN <i>8b</i> FORWARDED. <input type="checkbox"/> NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD. <input type="checkbox"/> MORE INFORMATION NEEDED. FURNISH FOLLOWING:
13. SIGNATURE	14. DATE	
REPLY/SECOND REFERRAL		
15. TO:		16. REMARKS <input type="checkbox"/> RECORDS CHECKED IN <i>8b</i> FORWARDED. <input type="checkbox"/> NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD. <input type="checkbox"/> MORE INFORMATION NEEDED. FURNISH FOLLOWING:
17. SIGNATURE	18. DATE	
19. RETURN TO: (<i>Include ZIP Code</i>) <div style="border: 1px solid black; width: 100%; height: 100%; margin: 5px 0;"></div>		 <i>REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.</i>

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MIL VA		
<input type="checkbox"/> <input type="checkbox"/> CLINICAL <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> HEALTH RECORD <input type="checkbox"/>		
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