REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION

REQUESTING ACTIVITY - *Complete Items 1 through 10 (Except 8b); 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 *(Last Name - First Name - Middle Name)*

2. ORGANIZATION AND PLACE OF TREATMENT

3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*

4. TO *(Include ZIP Code)*

5. IDENTIFYING INFORMATION

a. SERVICE NUMBER

b. GRADE/RATE

c. SOCIAL SECURITY ACCOUNT NO.

d. VA CLAIM NUMBER

e. DATE OF BIRTH *(If Federal employee)*

6. DATES OF TREATMENT *(Inclusive)*

7. DISEASE OR INJURY

8. a. RECORDS REQUESTED / b. RECORDS FORWARDED

MIL	VA		MIL	VA
☐	☐	CLINICAL	☐	☐
☐	☐	OUTPATIENT	☐	☐
☐		HEALTH RECORD	☐	
☐	☐	DENTAL RECORD	☐	☐
☐	☐	X-RAY	☐	☐
☐		MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	☐	
	☐	ABSTRACT OF RATING SHEET		☐
☐	☐	REPORT OF PHYSICAL EXAMINATION	☐	☐
☐		ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)*	☐	
☐	☐	OTHERS *(List under remarks)*	☐	☐

9. REMARKS

10. SIGNATURE

REPLY/REFERRAL

11. TO:

12. REMARKS

☐ RECORDS CHECKED IN 8b FORWARDED.

☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.

☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:

16. REMARKS

☐ RECORDS CHECKED IN 8b FORWARDED.

☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.

☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. SIGNATURE

18. DATE

19. RETURN TO: *(Include ZIP Code)*

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

Reset