

REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION	REQUESTING ACTIVITY - Complete Items i 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%; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 50%; height: 50%;"></div> <div style="border: 1px solid black; width: 50%; height: 50%;"></div> </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"/> OUTPATIENT	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> HEALTH RECORD	<input type="checkbox"/>	
<input type="checkbox"/> DENTAL RECORD	<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"/> 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"/> 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 8b 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 8b 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%; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 50%; height: 50%;"></div> <div style="border: 1px solid black; width: 50%; height: 50%;"></div> </div>		REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

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)		3. STATUS <input type="checkbox"/> MILITARY <input type="checkbox"/> VA BENEFICIARY <input type="checkbox"/> DEPENDENT <input type="checkbox"/> FEDERAL EMPLOYEE <input type="checkbox"/> OTHER (Specify)	
2. ORGANIZATION AND PLACE OF TREATMENT		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		9. REMARKS	
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"/>			
<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 (Except X-rays unless specifically requested) <input type="checkbox"/>			
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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.	