AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORDS REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE	DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/ SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER *(SSN or Other)*

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
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