

# REFERRAL FOR CIVILIAN MEDICAL CARE

SUBMIT CHARGES TO:  REFERRING UNIFORMED SERVICES FACILITY  CHAMPUS

<b>MEDICAL RECORD</b>	<b>CONSULTATION SHEET</b>
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REQUEST		
TO:	FROM: <i>(Requesting physician or activity)</i>	DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)*

ANTICIPATED LENGTH OF TREATMENT:  
PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	<input type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL <input type="checkbox"/> 72 HOURS <input type="checkbox"/> EMERGENCY
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**CONSULTATION REPORT**

*(Continued on page 2)*

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; hospital or medical facility)*

**DD FORM 2161**  
1 OCT 78

S/N 0102-LF-002-1611

PATIENT/RESPONSIBLE FAMILY MEMBER SIGNATURE \_\_\_\_\_

SPONSOR'S FULL SSAN \_\_\_\_\_

IMPORTANT INFORMATION *(on page 2)*

