

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: OMFS	FROM: <i>(Requesting physician or activity)</i> Ortho Dr. Kimura	DATE OF REQUEST 05/18/09
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REASON FOR REQUEST *(Complaints and findings)*

S: 42 year old MALE patient with need of orthognathic work up for 3pc Lefort, BSSO Advancement. Prior Hx of SARPE.
 B: Background: currently in surgical hooks and 19X25ss wires.
 A: MN A-P hypoplasia, MX transverse hypoplasia, missing #7, and third molars, OSA.
 R: Please evaluate as above.

PROVISIONAL DIAGNOSIS

MN A-P hypoplasia, OSA, MX transverse hypoplasia

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

RECORD REVIEWED <input type="checkbox"/> YES <input type="checkbox"/> NO	PATIENT EXAMINED <input type="checkbox"/> YES <input type="checkbox"/> NO	TELEMEDICINE <input type="checkbox"/> YES <input type="checkbox"/> NO
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ADDITIONAL INFORMATION:

Panoramic Radiograph (date-less than 1 year): _____
 other Radiographs: _____

Study Models for Implants: Y N
 Surgical Guide: Y N

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

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