

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: ORTHODONTICS	FROM: <i>(Requesting physician or activity)</i>	DATE OF REQUEST
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REASON FOR REQUEST *(Complaints and findings)*

S: ____ YEAR OLD MALE/ FEMALE PATIENT REQUESTS ORTHODONTIC EVALUATION
 B: BACKGROUND: _____ ETS/DEROS: _____
 A: CIRCLE: SKELETAL / MOLAR RELATIONSHIP CLASS I / CLASS II / CLASS III / don't know
 CIRCLE: GENERAL / ORTHOGNATHIC
 R: RECOMMENDATION FOR ORTHODONTIC EVALUATION FOR POSSIBLE TREATMENT.

***necessary additional information: Phone numbers w: _____ h: _____

PROVISIONAL DIAGNOSIS

New panoramic radiographs and study models are not necessary as new ones will be taken at evaluation appointment.

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

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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(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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STANDARD FORM 513 (REV. APR 1998)

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