

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: PERIODONTICS	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 with need of _____

B: Background _____

A: Assessment _____

R: Please evaluate # _____ or quads _____ for (circle) Periodontal Treatment / Crown Lengthening / Gingival Graft
other: _____

PROVISIONAL DIAGNOSIS

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

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: _____

(Continue on reverse side)

SIGNATURE AND TITLE	DATE
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HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT
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RELATION TO SPONSOR	SPONSOR'S NAME <i>(Last, first, middle)</i>	SPONSOR'S ID NUMBER <i>(SSN or Other)</i>
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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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Medical Record

STANDARD FORM 513 (REV. APR 1998)

Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)