AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO: Sexual Assault Medical Management Office (SAMMO)	FROM: *(Requesting physician or activity)*	DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)* SAMMO Services

ADVOCATE: Please advise the patient/victim of pending phone call from a Registered Nurse or Nurse Practitioner regarding available medical services.

ADVOCATE: Please advise the patient/victim of ability to accept or decline all or any portion of services during this call

ADVOCATE: Please return completed form to DDEAMC SAMMO within 72 hours of report. Send to both the SACC and SAMD to insure timely care: anne-marie.m.barlow.civ@mail.mil & victoria.a.franz.civ@mail.mil

PROVISIONAL DIAGNOSIS
Need for SAMMO

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
Digitally signed by FRANZ.VICTORIA.A.1015203249 DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=USA, cn=FRANZ.VICTORIA.A.1015203249 Date: 2017.01.25 08:46:39 -05'00'	FRANZ.VICTORIA.A.1015203249	☐ BEDSIDE ☑ ON CALL	☐ ROUTINE ☐ TODAY ☑ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

VA Contact Info:

Name:

Good Contact #

Type of Report : RESTRICTED or UNRESTRICTED (please circle one)

Date of Event:

(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.

Patient/Victim Information:

Name:

(Good) Contact Number:

Last Four SSN:

DOB: