

MEDICAL RECORD	<b>CONSULTATION SHEET</b>
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**REQUEST**

	FROM: Requesting physician or activity  <b>USMC OFFICER PROGRAM</b>	DATE OF REQUEST
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REASON FOR REQUEST (Complaints and findings)

**Cyclopalegic eye exam request**

PROFESSIONAL DIAGNOSIS  <b>PREFERRED</b>			
DOCTORS SIGNATURE	APPROVED	PLACE OF CONSULTATION <input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <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
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**AVIATION MANIFEST**

DISTANT VISION	REFRACTION	NEAR VISION
DT 20/    Corr. To 20/	By    S    CX	Corr. To 20/    By
DT 20/    Corr. To 20/	By    S    CX	Corr. To 20/    By

SIGNATURE AND TITLE		DATE
IDENTIFICATION NO.	ORGANIZATION	WARD NO.

PATIENTS IDENTIFICATION (For typed or written entries give: Name, Last, first, middle: grade: rate: hospital or medical facility)

NAME:  
SSN:  
DOB:  
PROGRAM:

**USMC OFFICER PROGRAMS**  
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