

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT <i>(Title and Number)</i>	ISSUANCE DATE
LOCAL FORM TITLE <i>(Optional)</i>	
DATE: _____ TIME: _____	
<input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT (Clinic, ER) <input type="checkbox"/> APV <input type="checkbox"/> Observation	
<input type="checkbox"/> AMA (Against Medical Advice) <input type="checkbox"/> LWBS (Left Without Being Seen)	
Area from which patient left AMA/LWBS _____	
Arrival Time _____ Time of Release _____	
Reason patient left AMA/LWBS:	
Initial problem / medical need which caused the patient to seek care at the Naval Hospital, Pensacola:	
In the patient's opinion, does the initial problem / medical need still exist?	
If "no", how was the problem / medical need resolved?	
If "yes", what plans / arrangements were made to resolve the problem / medical need?	
Interviewer's Signature: _____	
USE BACK OF FORM AS NEEDED FOR DOCUMENTATION OF INCIDENT. *Original copy to medical record; copy to Risk Manager and Command Patient Contact Representative with copy of ETR or Medical Record.	

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)</i>	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

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