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 *(Title and Number)*	ISSUANCE DATE
ADMISSION AND DISPOSITION OF PATIENTS, NAVHOSPCAMPENINST 6320.3L	30 DEC 2004

LOCAL FORM TITLE *(Optional)*
NAVAL HOSPITAL CAMP PENDLETON ADMISSION FORM

PART I: TO BE COMPLETED BY ADMITTING PHYSICIAN

APV YES NO	ADMITTING DATE/TIME	ADMISSION DIAGNOSIS	CLINICAL SERVICE
WARD	ER CHECK IN TIME	ADMITTING STAFF PHYSICIAN	

PART II: PATIENT INFORMATION

LAST NAME | FIRST NAME | MI

HOME ADDRESS (DO NOT USE BARRACKS) | WORK PHONE: | CELL (MOBILE) PHONE:

CITY | STATE | ZIP CODE

DATE OF BIRTH | SEX | RACE | RELIGION | MARITAL STATUS | ALLERGIES

PATIENT STATUS (PLEASE CHECK ONE)

- ☐ AD
- ☐ DEP/RET
- ☐ RET (LOS, TDRL, PRL)
- ☐ DEP/AD
- ☐ DEP/RET/DEC
- ☐ DEP/AD/DEC
- ☐ OTHER

IF RETIRED, GIVE RANK AND BRANCH OF SERVICE

IF ADMISSIONS IS DUE TO AN ACCIDENT - STATE THE CIRCUMSTANCES BRIEFLY:

TRANSFERRED FROM ANOTHER HOSPITAL? (IF YES, GIVE NAME AND ORIGINAL ADMISSION DATE)

PART III: SPONSOR INFORMATION (IF YOU ARE RETIRED PROCEED TO PART IV)

LAST NAME | First Name | MI

Rank/Rate | MOS/AFSC | LOS (LENGTH OF SERVICE) | BRANCH OF SERVICE

Complete Military Address | Duty Phone Number

PART IV: EMERGENCY INFORMATION (YOU MAY USE YOUR SPOUSE)

Name | Relationship

Home Address | Phone Number

THIS SECTION FOR USE BY HOSPITAL STAFF

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