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
ADMISSIONS	NAVHOSPPNCLAINST 6010.9X	20 Jan 2016

LOCAL FORM TITLE *(Optional)*
INPATIENT ADMISSION RECORD / DEERS ELIGIBILITY CHECK

Date: _____ Check one: ☐ Inpatient Admission ☐ Eligibility Check **ONLY**

1. Patient's Name (Last, First, MI): _____

2. Birth Date (DDMMYY): _____ Sex: _____ Family Member Prefix Number: _____

3. Religion: _____ Race: _____ Marital Status: _____

4. Home Address: _____

_____
City State Zip Code

Phone: _____ Work Phone: _____

5. Service: _____ Status: ☐ Active Duty ☐ Retired Rank: _____ Rate: _____

6. Station / Department: _____ Unit Location: _____

7. Length of Service (Years): _____ Flying Status: ☐ Yes ☐ No

8. Duty Station Address: _____

_____
City State Zip Code

Duty Phone: _____ DSN / AUTOVON: _____

9. Next of Kin and Emergency Information

Name: _____ Relationship: _____

Address: _____

_____
City State Zip Code

Phone: _____

THIS INFORMATION IS TO BE COMPLETED BY ADMISSIONS OFFICE

Date of Admission: _____ Time of Admission: _____ Clinical Service: _____

Admitting Diagnosis: _____

Admitting Physician: _____

Registration Number: _____ Ward: _____

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	