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
LOCAL FORM TITLE *(Optional)*	

BRANCH HEALTH CLINIC PUGET SOUND NAVAL SHIPYARD
PUGET SOUND NAVAL SHIPYARD C/062
1400 Farragut Ave, Bremerton WA 98314
(360) 476-5991 FAX (360) 476-2480

OCCUPATIONAL HEALTH
MEDICAL SURVEILLANCE EXAMINATION

PATIENT NAME:_____

(FIRST, MIDDLE INITIAL, LAST NAME)

The above named patient has elected to have a digital anorectal examination performed by his private physician.
Please address the specific questions and provide any additional information as needed.

PERTINENT MEDICAL HISTORY:

OBJECTIVE FINDING: DATE_____

WNL/ABNL ANORECTAL/PROSTATE EXAM
NEG/POS OCCULT BLOOD
POS/NEG PERFORMANCE CONTROL

WNL/ABNL TESTES

COMMENTS ON FINDINGS: (PLEASE CONTINUE ON REVERSE SIDE IF NECESSARY)

* Apply developer on Performance Control Are per manufacturer instruction. If blue color appears within 30 second confirming correct performance of reagent, mark positive, otherwise , mark negative.
** Exam must be performed by a MD, DO, NP or PA.

(PLEASE COMPLETE REQUIRED PROVIDER INFORMATION ON REVERSE SIDE)

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	

COMMENTS ON FINDINGS:

LICENSED PHYSICIAN SIGNATURE

PHYSICIAN NAME (TYPED OR PRINTED)

PHYSICIAN SPECIALTY

PHYSICIAN ADDRESS

PROFESSIONAL LICENSE NUMBER

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
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