REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION	**REQUESTING ACTIVITY** - Complete Items 1 through 10 *(Except 8b)*; also complete Item 19. **ADDRESSEE** - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, final referrer shall return to requester.	DATE

1. PATIENT *(Last Name - First Name - Middle Name)*

2. ORGANIZATION AND PLACE OF TREATMENT

3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*

4. **TO** *(Include ZIP Code)*

5. IDENTIFYING INFORMATION
   - a. SERVICE NUMBER
   - b. GRADE/RATE
   - c. SOCIAL SECURITY ACCOUNT NO.
   - d. VA CLAIM NUMBER
   - e. DATE OF BIRTH *(If Federal employee)*

6. DATES OF TREATMENT *(Inclusive)*

7. DISEASE OR INJURY

8. a. RECORDS REQUESTED / b. RECORDS FORWARDED

MIL	VA		MIL	VA
☐	☐	CLINICAL	☐	☐
☐	☐	OUTPATIENT	☐	☐
☐		HEALTH RECORD	☐	
☐	☐	DENTAL RECORD	☐	☐
☐	☐	X-RAY	☐	☐
☐		MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	☐	
	☐	ABSTRACT OF RATING SHEET		☐
☐	☐	REPORT OF PHYSICAL EXAMINATION	☐	☐
☐		ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)*	☐	
☐	☐	OTHERS *(List under remarks)*	☐	☐

9. REMARKS

10. SIGNATURE

REPLY/REFERRAL

11. **TO:**

12. REMARKS
   - ☐ RECORDS CHECKED IN 8b FORWARDED.
   - ☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
   - ☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. **TO:**

16. REMARKS
   - ☐ RECORDS CHECKED IN 8b FORWARDED.
   - ☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
   - ☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. SIGNATURE

18. DATE

19. **RETURN TO:** *(Include ZIP Code)*

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

DD FORM 877, SEP 67