Form not placed in the Medical Record. Form is for SAMMO information purposes only

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
SAMMO	SARC/VA	

REASON FOR REQUEST (Complaints and findings)

Sexual Assault Medical Management Services/ Care Coordination
ADVOCATE: Advise patient(victim) of pending phone call from RN or Nurse Practitioner advising of available/appropriate/ recommended medical services. Do they consent to this call? YES or NO Patient Initials_____
ADVOCATE: Advise pt they can decline or accept services during this call
SARC: MUST return this form to DDEAMC SAMMO within 72 hours. Send via ENCRYPTED e mail to BOTH the SAMD and SACC to ensure timely appropriate care. (1) SAMD: victoria.a.franz.civ@mail.mil (2)SACC: anne-marie.m.barlow.civ@mail.mil

PROVISIONAL DIAGNOSIS

Need for additional services: SAMMO

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
		☐ BEDSIDE ☒ ON CALL	☐ ROUTINE ☐ TODAY ☒ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORDS REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

ADVOCATE: Complete the following information (in full)
Patient (victim) Information:
Name:_____Phone#:_____(ensure this is a GOOD contact #)
Last4 of SSN#: _____
DOB:_____(day)_____(month)_____(year)
Unit:_____
Service Member?_____or Dependent of service member?_____
Date of occurrence:_____(day)_____(month)_____(year)
Date of report: _____(day)_____(month)_____(year)
Type of Report: Restricted _____ Unrestricted_____
Sexual Assault? YES_____ NO_____
Domestic Violence? YES_____NO_____
Did patient (victim) get medical care? YES_____NO_____ If Yes, WHERE?_____
Was a Medical-Forensic Exam conducted? YES_____NO_____
Miscellaneous information/comments to medical staff:

VA Contact Information:
Name:_____Phone#:_____(ensure this is a GOOD contact #)

(Continue on reverse side)

SIGNATURE AND TITLE	DATE
FRANZ.VICTORIA.A.1015203249 Digitally signed by FRANZ.VICTORIA.A.1015203249 Date: 2018.08.09 11:45:25 -04'00'	

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/ SERVICE OF PATIENT
DDEAMC		SAMMO

RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER *(SSN or Other)*

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
Patient (victim) Information:		

Name:_____

Phone#:_____(ensure this is a GOOD cont act #)
Last4 of SSN#: _____
DOB:_____(day)_____(month)_____(year)

CONSULTATION SHEET
Medical Record