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)*	3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*
2. ORGANIZATION AND PLACE OF TREATMENT	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
PREVIOUS	

8. a. RECORDS REQUESTED	MIL	VA	b. RECORDS FORWARDED 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)*	
DEPARTMENT OF THE NAVY NAVAL HEALTH CARE NEW ENGLAND RADIOLOGY DEPARTMENT 43 SMITH ROAD NEWPORT RI 02841-1002	*REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.*

DD FORM 877, SEP 67 (EG) REPLACES EDITION OF 1 JAN. 60. WHICH MAY BE USED. USAPPC V1.00